



Review Body on Doctors' and Dentists' Remuneration

Thirty-Third Report 2004

Chairman: Michael Blair, QC



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**Presented to Parliament by the
Prime Minister and the Secretary of State for Health**

**Presented to the Scottish Parliament by the
First Minister and the Minister for Health and Community Care**

**Presented to the National Assembly for Wales by the
First Minister and the Minister for Health and Social Services**

**by Command of Her Majesty
March 2004**

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. The review was conducted under the terms of reference introduced in 1998, amended in 2003 and reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the Secretary of State for Scotland and the Secretary of State for Wales on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

the need to recruit, retain and motivate doctors and dentists;

regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;

the Health Departments' output targets for the delivery of services as set out by the Government;

the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the Secretary of State for Scotland, the Secretary of State for Wales and the Prime Minister¹.

¹ Under the Scotland Act 1998 and the Government of Wales Act 1998 responsibility for health matters, including the pay of NHS staff in Scotland and Wales, has passed to the Scottish Executive and the National Assembly for Wales respectively. In addition to our usual addresses, our recommendations are therefore addressed to the First Minister and the Minister for Health and Community Care of the Scottish Executive and to the First Minister and the Minister for Health and Social Services of the National Assembly for Wales.

The members of the Review Body are:

Michael Blair, QC (*Chairman*)
Professor John Beath²
Professor Frank Burchill
Dr Margaret Collingwood³
Hugh Donaldson, Esq
Professor Alexander Dow
Dr Gareth Jones

The Secretariat is provided by the Office of Manpower Economics.

² Professor John Beath was appointed to the Review Body by the Secretary of State for Health from November 2003.

³ Dr Margaret Collingwood was appointed to the Review Body by the Secretary of State for Health from November 2003.

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Summary of recommendations and main conclusions

Our recommendations are for implementation on 1 April 2004.

Chapter 1 – Economic and General Considerations

- We have approached this round on the basis that we do not intend to disrupt what has already been agreed between the parties, and accepted by our remit groups in their contract ballots (paragraph 1.5).
- Our aim is to make balanced recommendations and we are exercising our judgement independently, taking due account of the risk of non-delivery of the service and judging against all the provisions of our terms of reference what is necessary, as far as pay is concerned, to deliver and retain adequate numbers of good quality, motivated staff (paragraph 1.55).
- We welcome the Department's collaborative approach to gathering more detailed evidence on regional and local pay issues affecting our remit groups. We would also remind all the Departments that evidence on regional/local pay should cover all medical and dental grades, and not just consultants (paragraphs 1.65 and 1.72).
- We **recommend** (recommendation 1) that London weighting is increased in 2004-05 by 2.5 per cent, in line with the Government's inflation target (paragraph 1.86).

Chapter 2 – General medical practitioners (GMPs)

- For 2004-05, we **recommend** (recommendation 2) that the salary range for salaried GMPs employed by a Primary Care Organisation should be £47,710 to £72,478 (paragraph 2.19).
- We **recommend** (recommendation 3) that the out-of-hours supplement for GMP registrars should remain at 65 per cent of basic salary during 2004-05 (paragraph 2.33).
- For this round, we **recommend** (recommendation 4) that the level of the GMP trainers' grant is uplifted by 3.225 per cent for 2004-05 (paragraph 2.42).
- We **recommend** (recommendation 5) that the Department of Health view GMPs working in community hospitals as a priority in taking forward its review of clinical assistants and hospital practitioners. We would expect to hear reports of good progress for our next review (paragraph 2.53).
- We **recommend** (recommendation 6) that sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities are increased by 3.225 per cent for 2004-05 (paragraph 2.61).

Chapter 3 – General dental practitioners (GDPs)

- Consideration of the parties' evidence this year was set against the background of the forthcoming change to the arrangements for NHS dentistry in England, when from April 2005, local commissioning and funding of dental services through Primary Care Trusts (PCTs) will be introduced. The year to which our recommendations apply (2004-05) will therefore be a transitional year in England before the new arrangements come into effect. In making our recommendations for this round, we have focused on the need to facilitate the move to this new regime (paragraph 3.1).
- We note the Department of Health's admission that it has failed to compete effectively for the services of the workforce and the Minister's wish to reverse the trend and to begin to rebuild the General Dental Services (GDS). We accept the point that to compete effectively with rates that can be earned in private practice would require very substantial increases in the feescall and the affordability aspect of our remit would preclude any recommendations on our part which achieved such an alignment (paragraph 3.41).
- We hope that the Department's argument that PCTs will be able to fund locally measures to support dental practices will prove correct, though we are concerned that PCTs in reality are likely to have many competing demands for funding (paragraph 3.44).
- We considered the issue of the "lag effect" in our Twenty-Sixth Report and made our recommendation accordingly. We do not intend to re-open the matter at this time and particularly when, in England at least, we are entering the final year of the current system of remuneration for GDPs working within the GDS. However, we would expect the future arrangements for local contracting to seek to avoid any significant financial disadvantage arising for practitioners as a consequence of the way in which the annual funding uplift is implemented (paragraph 3.49).
- We **recommend** (recommendation 7) that the Commitment Payments scheme is uplifted in accordance with our general recommendation for GDPs this round (paragraph 3.51).
- As we are required to balance the interests of the taxpayer against those of our remit groups, we see no justification for recommending that GDPs should retain their seniority and commitment payments once they start drawing their NHS pension (paragraph 3.56).
- We would stress to the parties again that we see an acceptable and agreed estimate of total remuneration for whole-time equivalent (WTE) GDPs as important information for our deliberations, even under the new arrangements. We therefore **recommend** (recommendation 8) that their work on reforming the GDS takes this information need into account, so that a reliable and agreed baseline for the remuneration of WTE GDPs fully committed to the GDS can be established for the reformed GDS, which can then be updated each round (paragraph 3.60).
- We asked the parties in our last report to address the question of expenses as part of the work to develop new methods of remuneration under *Options for Change*, and we therefore ask for a report of progress here for the next round. Expenses are of concern to us and we therefore **recommend** (recommendation 9) that they are given proper consideration under the new regime (paragraph 3.66).

- For the next round, we would also ask the parties for evidence on the deployment of the £35 million capital funding announced by the Department last September for use in 2003-04 and 2004-05. We consider it important that this funding should be fully spent over these two years, and we would also expect the funding to be targeted at those practitioners with the greatest commitment to the NHS and the greatest need for support (paragraph 3.78).
- We repeat our request for the parties to take forward work on testing out a practice allowance at the *Options for Change* field sites and to report to us in the next round (paragraph 3.86).
- In our view, even if the new local contracting regime is transparent and easy to interpret, a structured change management programme will be needed for dentists and their staff to prepare them for the new arrangements. We consider that the funding of £670,000 for 2004-05 is likely to be inadequate and would therefore **recommend** (recommendation 10) that the Department of Health consider making available a more appropriate level of additional funding, which should be targeted locally through PCTs, in support of a structured change management programme (paragraph 3.93).
- While we very much hope that the treadmill of the item-of-service feescal will go from day one, as the Department says, it nevertheless remains unclear to us how this will be achieved when the new base contract will require broadly comparable levels of work for broadly the same level of current gross income (uplifted by our recommendations) (paragraph 3.98).
- Our view is that our recommendation for 2004-05 should include a small real terms increase in the feescal. While we realise that a small real terms increase will have little effect in closing the gap between NHS and private dentistry earnings, we hope that it will go some way towards stabilising the retention of GDPs in the GDS, particularly as we head into the new regime. We therefore **recommend** (recommendation 11) that gross fees for items of service and capitation payments should be increased by 2.9 per cent for 2004-05 for GDPs. We also **recommend** (recommendation 12) that sessional fees for taking part in emergency dental services be increased by 2.9 per cent (paragraph 3.99).

Chapter 4 – Salaried Primary Dental Care Services (SPDCS)

- As part of the second year of the three-year pay deal, we note that the parties have agreed a 3.225 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2004-05. We therefore endorse and **recommend** (recommendation 13) this (paragraph 4.5).

Chapter 5 – Ophthalmic medical practitioners

- We feel that a unified sight test fee for ophthalmic medical practitioners (OMPs) and optometrists, set in negotiation between the Health Departments and representatives of both optometrists and OMPs, remains appropriate and **recommend** (recommendation 14) accordingly (paragraph 5.10).

Chapter 6 – Doctors and dentists in training

- We consider that the current levels of the banding multipliers, as negotiated between the parties, are now set at a rate that fully reflects the out-of-hours commitment and intensity of posts. In the absence of any detailed evidence as to why the current levels of the pay banding multipliers might be inappropriate, we **recommend** (recommendation 15) that the percentage values of the current multipliers be rolled forward for another year (paragraph 6.41).
- We do not intend to lose sight of the fact that the levels of basic pay must be kept under review as the effect on earnings of the pay banding multipliers begins to decrease (paragraph 6.44).
- We are satisfied that the evidence demonstrates that some specialist registrars (SpRs) are becoming stuck at the top of their payscale, and **recommend** (recommendation 16) the awarding of one extra incremental point to the SpR grade, subject to satisfactory performance (paragraph 6.61).
- We hope that a workable solution can be arrived at quickly between the parties who are agreed on the need for a review of the current contract as it applies to flexible trainees, as we consider that this needs urgent resolution (paragraph 6.72).
- We **recommend** (recommendation 17) an increase of 2.7 per cent on the salary scales of all grades of doctors and dentists in training (paragraph 6.90).

Chapter 7 – Consultants

- As requested by the parties, we duly endorse and **recommend** (recommendation 18) a 3.225 per cent pay uplift for 2004-05 and for 2005-06 for those consultants on the new contract, in order to give effect to years two and three of the agreed ten per cent three-year pay deal (paragraph 7.52).
- We consider that the agreement on which consultants were balloted last autumn should stand as negotiated while the three-year pay deal runs its course. Only when the contract has been operating widely for a period of time can an assessment be made about any shortcomings and areas which may need to be reconsidered (paragraph 7.59).
- In our view, the solution to the problems of workload and morale and a desire for greater career flexibility are intended to be addressed through the new contract; it is our intention not to disrupt what has been agreed between the parties and accepted by the remit groups in their contract ballots. The decision about whether to stay on the existing contract will be a personal one, and will take into account a range of considerations for the individual concerned which may be of no relevance to our particular remit. We therefore **recommend** (recommendation 19) an increase of 2.5 per cent for 2004-05 on the national salary scale for the existing contract (the pre-2003 contract) (paragraph 7.71).
- We endorse and **recommend** (recommendation 20) the introduction of the new Clinical Excellence Awards scheme, as described in the documentation on which consultants were balloted last autumn (paragraph 7.106).

- We **recommend** (recommendation 21) that the value of Clinical Excellence Awards (and distinction awards currently in payment) should be uplifted by 3.225 per cent in 2004-05 (paragraph 7.108).
- We **recommend** (recommendation 22) that the initial funding baseline for higher level Clinical Excellence Awards in England and Wales in 2004-05 should be the 2003-04 funding baseline for the distinction awards scheme, increased by £8.5 million, as recommended by ACCEA, and our pay uplift recommendation for the new consultant contract of 3.225 per cent (paragraph 7.109).
- In Scotland, we **recommend** (recommendation 23) that the value of the discretionary points and distinction awards should be uplifted by 3.225 per cent in 2004-05. We also endorse and **recommend** (recommendation 24) the proposal from SACDA for 24 new distinction awards at the following levels: two 'A+' awards, seven 'A' awards, and 15 'B' awards (paragraph 7.112).

Chapter 8 – Staff and associate specialists/non-consultant career grades (SAS/NCCGs)

- We remain concerned about the consequences for morale of any delay in implementing changes to the remuneration system in the light of the review of these doctors and dentists. We **recommend** (recommendation 25) that the Health Departments make this work a high priority. We expect the Departments to report measurable and identifiable progress towards reaching an agreed outcome by the time we hear oral evidence later this year (paragraph 8.35).
- We have asked the Department of Health for evidence for our next review that the discretionary points schemes for SAS/NCCGs are being operated effectively in Trusts across Great Britain (paragraph 8.37).
- We **recommend** (recommendation 26) that an extra discretionary point is added to the top of the discretionary scale for associate specialists and staff grades on the post-1997 contract (paragraph 8.38).
- We **recommend** (recommendation 27) an increase of 2.7 per cent for 2004-05 on the national salary scales of SAS/NCCGs. In addition, we wish to recognise that those at the top point of the incremental scale have not benefited in the same way as others in recent years. Any further loss of morale amongst this group could mean a real risk of deterioration of service. We therefore **recommend** (recommendation 28) that with effect from 1 April 2004, the final incremental point for associate specialists be increased to £60,000 and for staff grades should be increased to £42,500. For staff grades, this latter recommendation should only apply to those on the post-1997 contract (paragraph 8.42).
- We **recommend** (recommendation 29) that the parties consider rationalisation of the two contracts for SAS/NCCGs as part of the SAS/NCCG review (paragraph 8.46).

Our main recommendations on pay levels are:

	<i>Point on scale¹</i>	<i>Recommended basic scales 1 April 2004 £</i>
<i>Hospital doctors and dentists – main grades (whole-time salaries):</i>		
House officer	minimum	19,703
	maximum	22,240
Senior house officer	minimum	24,587
	maximum	34,477 ²
Specialist registrar ³	minimum	27,483
	maximum	41,733 ⁴
Staff grade practitioner	minimum	29,845
	maximum (normal)	42,500 ⁵
	maximum (discretionary)	56,732 ⁶
Associate specialist	minimum	33,090
	maximum (normal)	60,000 ⁵
	maximum (discretionary)	72,882 ⁶
Consultant (pre-2003 contract)	minimum	55,699
	maximum (normal)	72,483
	maximum (discretionary)	95,899 ⁷
	distinction award 'B'	29,203
	distinction award 'A'	51,102
	distinction award 'A plus'	69,347
Consultant (post-2003 contract, England and Scotland)	minimum	67,133
	maximum (normal)	90,849
	maximum (CEA)	32,424 ⁸
	CEA ⁹ (bronze)	32,424
	CEA (silver)	42,622
Consultant (post-2003 contract, Wales)	CEA (gold)	53,278
	CEA (platinum)	69,261
	minimum	65,032
	maximum	79,391 ¹⁰
	maximum (commitment award ¹¹)	23,416

¹ Salary scales exclude additional earnings, such as those related to banding multipliers for doctors in training.

² To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21.

³ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁴ New incremental point, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of this report.

⁵ Top incremental point extended, see paragraph 8.42 of this report.

⁶ New discretionary point, see paragraph 8.38 of this report.

⁷ Eligibility for discretionary points is after five years' service as a consultant. The figure represents a notional salary where the value of the maximum discretionary point has been added to the maximum of the scale.

⁸ Eligibility for Clinical Excellence Awards (CEAs) is after one year's service as a consultant. The figure represents the value of the maximum CEA awarded by local committee.

⁹ Higher CEAs awarded by the Advisory Committee on Clinical Excellence Awards (ACCEA).

¹⁰ Until December 2004.

¹¹ A total of eight commitment awards are awarded (one every 3 years) once the maximum of the scale is reached.

	<i>Point on scale¹</i>	<i>Recommended basic scales 1 April 2004 £</i>
<i>Community health staff – selected grades (whole-time salaries):</i>		
Clinical medical officer	minimum	28,551
	maximum	39,730
Senior clinical medical officer	minimum	40,736
	maximum	58,493
<i>Salaried primary dental care staff – selected grades</i>		
Community dental officer	minimum	30,313
	maximum	48,016 ¹²
Senior dental officer	minimum	43,721
	maximum	59,422 ¹³
Clinical director	minimum	58,410
	maximum	66,694 ¹³

MICHAEL BLAIR QC (*Chairman*)
PROFESSOR JOHN BEATH
PROFESSOR FRANK BURCHILL
DR MARGARET COLLINGWOOD
HUGH DONALDSON
PROFESSOR ALEXANDER DOW
DR GARETH JONES

OFFICE OF MANPOWER ECONOMICS
27 February 2004

¹² Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First Report.

¹³ Performance based increment, see paragraphs 4.21 and 4.38 of the Thirty-First Report.

Part I: Overview

CHAPTER 1: ECONOMIC AND GENERAL CONSIDERATIONS

Conduct of the 2004 review

- 1.1 *Our review was conducted under the terms of reference introduced in 1998, as amended in July 2003, and which are reproduced at the beginning of the report. The outcome of the last review is set out at Appendix C.*
- 1.2 *Since we last reported, there have been two significant developments affecting our remit groups. General medical practitioners (GMPs) voted in June 2003 to accept the introduction of a new contract for General Medical Services (GMS) in Great Britain. This means that we are not required to make recommendations on remuneration for independent contractor GMPs for 2004-05 or 2005-06. In autumn 2003, separate ballots were held for consultants across England, Scotland and Wales on their respective new contracts. In each country, consultants voted to accept these contracts and work is now proceeding on implementation. The new contract will apply to all consultants in Wales, whereas in England and Scotland, existing consultants must opt to take up the new contract. We are therefore only required to make recommendations for 2004-05 in respect of those consultants in England and Scotland who remain on the old contract. Nor are we required to make recommendations for 2004-05 in respect of staff working in the salaried primary dental care services, as the parties agreed a three-year pay deal for this group in March 2003.*
- 1.3 *For the 2004 review, we are therefore required to make recommendations on the following groups – doctors and dentists working within the Hospital and Community Health Service, salaried GMPs employed by a Primary Care Organisation (PCO), GMP registrars, general dental practitioners (GDPs), and ophthalmic medical practitioners (OMPs). These groups equate to around 60 per cent of our total remit group, as shown in the table below. A chart showing those groups for whom we are required to make a recommendation is also shown at Appendix D.*

Remit staff group under consideration for the 2004 review¹

	Headcount, GB		
	Being considered	Not being considered	Total
Consultants ²	11,260	20,530	31,790
Associate specialists/staff grades	8,340		8,340
Registrar group	16,020		16,020
Senior house officers	20,700		20,700
House officers	6,240		6,240
Other ³	8,980		8,980
GMS principals		33,570	33,570
Other GMS staff ⁴		3,090	3,090
GDPs	22,190		22,190
Salaried dentists ⁵		2,000	2,000
Ophthalmic medical practitioners	750		750
Total	94,480	59,190	153,670

1. From Health Departments' censuses, at September 2002.

2. The percentages of consultants who voted in favour of the new contract in the national ballots have been used to calculate the number of consultants not being considered in this review.

3. Includes clinical assistants, hospital practitioners and public health and community medical staff not elsewhere specified.

4. Excludes GP registrars, whose basic pay is linked with senior house officers.

5. Includes community dental staff and salaried dentists working in the GDS.

- 1.4 *We very much welcome the progress which the parties have been able to make on the GMS contract and the consultant contract since we last reported. We know that both sides have viewed the agreement of new contracts for these groups as important for both doctors and the NHS. We therefore welcome the decision by GMPs and consultants to support the change and we hope that implementation of the contracts for both groups will proceed satisfactorily. Having agreed new contractual arrangements with a supporting three-year pay deal, we would expect the new contractual arrangements for both groups to be implemented, as agreed, and to bed in over the initial three-year period. As we wish to see from experience how the new arrangements are working in practice, we would ask the parties to keep us informed of progress during this initial period.*
- 1.5 *We have therefore approached this round on the basis that we do not intend to disrupt what has already been agreed between the parties, and accepted by our remit groups in their contract ballots. With regard to GDPs, the parties have told us that a new regime is due to be implemented for this group in England from April 2005. We indicated to the Minister during oral evidence that we intended to focus on facilitation of this new regime in our recommendations this round. We discuss GDPs in more detail in chapter three.*
- 1.6 *For this round, we have received written and oral evidence from the three Health Departments for Great Britain, the representatives of which were led by the Minister of State for Health; the NHS Confederation; the British Medical Association (BMA); the British Dental Association (BDA); and the General Dental Practitioners' Association (GDPA). We have also received written evidence from the Advisory Committee on Clinical Excellence Awards (ACCEA), which was formerly the Advisory Committee on Distinction Awards (ACDA); the Scottish Advisory Committee on Distinction Awards (SACDA); and the Hospital Consultants and Specialists Association (HCSA). The evidence from the Health Departments was set in the context of various policy documents, details of which, as well as the BMA's statement on its approach to the geographical coverage of its evidence, are set out at Appendix E.*
- 1.7 *As part of our preparation for this review, we continued our programme of visits in England, Scotland and Wales to NHS Trusts, to a primary care trust (PCT) and a Local Health Board, and to medical and dental practitioners. In view of the late running of the last round, the 2003 visit programme was truncated, but we were able to see members of each of our remit groups. Our schedule of visits for 2004 will be fuller. As always, we found the visits and meetings to be valuable and would like to thank all those who helped to arrange the programme, and who gave their time to participate in it.*

The Review Body's revised terms of reference

- 1.8 *As we commented in the opening paragraph, we have conducted our review under the revised terms of reference notified to us in July 2003¹. This requires us to also have regard to regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists. We are aware that the Government is also discussing with the professional bodies the introduction of a further change requiring us to have regard to the principle of equal pay for work of equal value in the NHS, and to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability. We await further advice from the parties about their progress here and when these further changes will be implemented.*

Reaction to the 2003 review

- 1.9 Commenting on the observation in our last report that our recommendations had been framed so as to be fair in relation to our terms of reference, and to avoid clouding any future discussions between the parties about pay, the **BMA** said that it understood our position, but discussions would be taking place for some time yet. In the meantime, it said there was no reason to delay implementing pay rates which fully reflected workload and the labour market position of doctors and dentists. Instead the BMA considered that the parties should take account in their negotiations of remuneration already received as the process of contractual change was a lengthy one and doctors and dentists should not suffer in the interim.

The current round

- 1.10 The **Government** set out its evidence on the general context for the round. Improving standards of public services remained at the heart of its priorities. It said that evidence suggested that public sector pay systems were less regionally and locally responsive than private sector ones, and this required attention. The resource envelope for the public sector had been set in the 2002 Spending Review and it said that adequate resources were available to achieve improved services. Pay and workforce issues remained at the heart of these agendas:

- recruitment and retention of the right number of people with appropriate skills and experience;
- pay and pay systems must encourage and reward high quality service delivery;
- unnecessarily high paybills would divert resources away from the higher quality services and threaten key objectives; and
- public sector pay systems must increase the sector's flexibility and responsiveness so it could contribute to increasing the overall flexibility of the economy.

- 1.11 Pay recommendations needed to have regard to these considerations. It repeated the point from previous years that outcomes which threatened the achievement of improved public services and economic flexibility would not be acceptable.

- 1.12 The **BMA** noted that the background this year was again unusual. Both the GMP and consultant contracts recognised current workload and the additions to job weight imposed by staff shortage and intensity of work. These had implications for the remit groups whose contracts were not being renegotiated and for those consultants opting to remain on the existing contract. The BMA said it would be wrong not to recognise that these doctors were subject to the same workload pressures, and that their performance was sustained at high levels or was improving without explicit financial incentive. In 2004-05, the BMA said that GMP average net income was expected to be around 19 per cent higher than in 2002-03, and the Health Departments expected to spend the equivalent of ten per cent more on consultant pay than the 2002-03 pay bill – an increase of 15 per cent and seven per cent respectively over the 3.225 per cent pay increase awarded to most doctors in 2003-04.

- 1.13 The **BDA** said that the BMA would be submitting evidence on behalf of all hospital staff and asked us to note that the issues raised by the BMA were applicable to those working in the Hospital Dental Service.

- 1.14 The **NHS Confederation** said that although this year's circumstances were not identical, they could again be described as exceptional. It was therefore not presenting detailed evidence, but it was simply setting out its recommendations.

Recruitment, retention, morale and motivation, and workload of our remit groups

- 1.15 *Detailed summaries of the Health Departments' position on the recruitment, retention, morale, motivation and workload of each of our remit groups, as well as the professional bodies' views, are given under the relevant chapters of this report.*
- 1.16 The **Health Departments** described the latest position on medical and dental staff recruitment, retention and motivation in the Hospital and Community Health Service (HCHS) in Great Britain. Medicine and dentistry were said to remain very attractive careers which continued to attract high levels of applications from those with the highest qualifications. The number of UK applicants to study medicine at UK universities was at its highest since 1986².
- 1.17 The Departments reported that the recruitment position had continued to improve over the past year, with further increases in hospital doctor and dentist numbers in 2002 and faster growth than the previous year. The total numbers of medical and dental staff in the HCHS increased by 5,020 (whole-time equivalent (wte)) or 6.6 per cent in 2002. Over the past five years, total HCHS staff numbers had increased by 12,910 (wte) or 18.9 per cent (3.8 per cent per year annualised). The medical workforce had grown by 7,340 (wte) or 9.9 per cent over the last two years with further increases planned.
- 1.18 On retention, the **Department of Health** said it was taking various actions to retain current staff within the overarching *HR in the NHS Plan* strategy for England (discussed in more detail later). On workforce planning, the Department said that it modelled the whole medical workforce, taking into account the age profile and grade structure. The assumptions supporting these models were underpinned by analysis of changing leaving and changing rejoining rates at each age. This implicitly took into account the effect of emerging changes in participation rates, for example, amongst staff in their 30s and early 40s. The models also took into account emerging changes in the ratio of whole-time equivalent to headcounts, separately at each grade.
- 1.19 The Department said that monitoring of retirement and retention trends also formed an integral part of its workforce planning assumptions and models, which it described in some detail. It concluded from the latest available data that whilst there were some indications of a small shift towards early retirement, the numbers involved were small and would have only a marginal impact on total numbers overall. Updated data from the NHS Pensions Agency on consultant retirements for England and Wales showed there was no clear trend and the total number of retirements had fallen in the last two years. The existing evidence on retirement trends, quoted to us in previous years, showed from the last actuarial investigation of the NHS Pension Scheme by the Government Actuary's Department in 1998, that the projected figure for the average age of retirement for male hospital doctors was 63.3, indicating a small change over a ten year period from the previous figure of 63.9. This change was reflected in workforce models.

¹ As part of our remit, we are required, amongst other things, to have regard to the Government's inflation target. In doing so we noted the announcement by the Chancellor of the Exchequer on 10 December 2003 that the Government's inflation target would in future be set using the consumer prices index (CPI) rather than the retail prices index excluding mortgage interest payments (RPIX). As with other Review Bodies, we have continued for the purposes of this report to have regard to the existing measure, on which the evidence submitted to us has been based.

- 1.20 General retention rates were said not to show any unwelcome trends and workforce planning models also factored in non-retirement leavers. This year's updated analysis from the Medical Careers Research Group (MCRG) on overall wastage rates five years after qualifying showed that the percentage of graduates not practising medicine after five years had remained quite low for all cohorts, with no clear trends over time. The Department reported that there was no new MCRG data this year on early retirement intentions, and reminded us that the MCRG survey had previously made clear that changes in pay would have at most only a marginal effect on retirement intentions. Of those considering early retirement, only six per cent quoted financial considerations as the reason, with a much greater emphasis being placed on the desire for more flexible working patterns and general improvements to working conditions. The Department said these were key components of its HR initiatives.
- 1.21 The Department of Health concluded that recruitment, retention and return policies were working, but there was no room for complacency.
- 1.22 The Department reminded us that improving morale and motivation was a key element of *HR in the NHS Plan*, which took forward the commitment to deliver more staff, working differently. It said that significant progress was being made and that the NHS was generally regarded as being ahead of both the public and private sectors in terms of offering a flexible and supportive working environment for all staff, including doctors. Various HR initiatives were underway or in the pipeline, including:
- *Staff survey* – a new national staff opinion survey was introduced in October 2003 to measure satisfaction and give an indication of morale;
 - *Improving Working Lives (IWL)* – this initiative remained a key recruitment and retention tool for all staff. The IWL intercollegiate working group of the Medical Royal Colleges had appointed an IWL Champion for Doctors;
 - *NHS Childcare Strategy* – the development of a childcare strategy for the NHS remained a key part of improving working lives. A further £100 million was committed for 2004-05 to ensure that childcare needs for all staff were met. Hospital doctors, GMPs and GMP registrars were covered by this and special consideration for the needs of doctors had to be built into local strategies;
 - *maternity, paternity and adoption leave* – staff directly employed in the NHS (including doctors) would be entitled to an extra four weeks' maternity pay. Discussions continued about improvements more widely;
 - *Flexible Careers Scheme (FCS)* – developed with the BMA, it provided for hospital doctors to work part-time (50 per cent or less), have temporary career breaks, or continue working, but at a different pace (benefiting the retired, semi-retired or those nearing retirement), and for flexibly trained specialist registrars (SpRs) taking up a first consultant post to work up to eight sessions per week. The FCS had received a very positive response. Enquiries had been received from over 1,300 hospital doctors, and over 300 applications had been submitted, 190 doctors were either on or about to start on the scheme (including 47 returners), and 33 had completed the scheme;
 - *Flexible Retirement Campaign* – since June 2003, all doctors requesting a pensions estimate or applying to take their pension had been sent information setting out their options, which was also being sent to doctors over 50 who had retired in the last ten years. The FCS was also attracting strong interest from older doctors; and

- *Doctors' Forum* – led on a range of initiatives affecting doctors, including extending the FCS to GMPs and developing the medical returners campaigns.
- 1.23 The position on dentists working within the General Dental Services (GDS) however was less positive. Although the Health Departments reported more dentists in the GDS in Great Britain than ever before (21,455 dentists as at 31 March 2003, 99 more than the year before), the Department of Health acknowledged that a number of dentists were reducing their NHS commitment. This is discussed in more detail in chapter 3 of the report.
- 1.24 The **SEHD** described the context for Scotland within which it was pursuing action on health improvement. Pay modernisation was said to be an absolute priority. Various initiatives existed to take forward workforce development, to review education and training in the NHS, and to consider retirement, retention and career development. The total number of doctors and dentists employed in the HCHS in Scotland was reported to have increased by 607 (7.17 per cent) in 2002. Various HR initiatives intended to support motivation were also underway.
- 1.25 The **National Assembly for Wales** reported that over the past five years, total hospital, public health medicine and community health service medical and dental staff had increased by 632 (wte) or 17.9 per cent. The recruitment position had continued to improve over the past year with the medical workforce growing by 269.9 wte (7.3 per cent) over the last two years. Targets had been set for staff increases and to reduce staff shortages, and to improve wastage and turnover rates. The Assembly described a number of HR initiatives, including an all-Wales NHS Staff Opinion Survey which had been carried out in 2002. The results had shown that a majority of the 22,000 NHS staff taking part expressed general satisfaction with the quality of working life, and had reported a flexible working environment and culture of open communication.
- 1.26 The **BMA** considered that the market for doctors remained a tight one, despite the recent increase in medical school places. The results of the most recent annual census of the NHS medical workforce in England had shown overall growth of 4.1 per cent in the medical workforce, which was above last year's 3.2 per cent and also the previous two years' growth of 2.7 per cent per year, with similar growth rates experienced in Scotland. However, this growth had been very uneven across sectors and, once again, most of it had occurred in the hospital sector, which had grown by 5.9 per cent (4.6 per cent last year). The BMA's more detailed views on each remit group are set out in the relevant chapters.
- 1.27 The **BDA** believed that there was a serious shortage of dental personnel in the UK and declining commitment to the NHS. The BDA's more detailed views on general dental practitioners (GDPs) are set out in chapter 3.

Comment

- 1.28 *We comment in more detail in the relevant chapters on the recruitment, retention, morale and motivation issues affecting our remit groups, and on their workload, but would also make some observations here.*

² The recruitment of medical and dental students is discussed in more detail in chapter 6.

- 1.29 On **recruitment**, we note that the latest figures for applications to medical schools indicates that medicine remains a popular career choice and is continuing to attract high levels of applications from those with the highest qualifications. We would also be interested to see how the number of applications per university place has varied in recent years, given the expansion in the number of medical school places, and would ask the Health Departments for these data by gender for our next review. We note that recruitment within the HCHS has continued its recent upward growth trend and we would expect this trend to continue as the recruitment of medical staff to the NHS is centrally planned in the main and depends on decisions made by the Government about the numbers required in the workforce in the future. Overall, the number of doctors and dentists working in the NHS has continued to rise, but not all groups have shown strong growth, with GPs showing the smallest rise amongst the groups for whom we must make recommendations this year. We have commented before on the danger that, taken in isolation, headcount figures can disguise any tendency to work for the NHS part-time and we were pleased that the Health Departments are continuing to monitor growth within the HCHS on a whole-time equivalent basis, as well as a headcount basis. The Departments have provided evidence this round on the changes in headcount and whole-time equivalent numbers for both Great Britain and for each individual country, as we requested in the last round. We are grateful for this information and would ask for it to continue to be presented in the future. We also asked for evidence in the last round on the workforce planning assumptions for part-time working of the medical workforce throughout the period covered by the Departments' current staffing targets, and how they were comparing to outturn working patterns. The Departments have confirmed that part-time working is taken into account in workforce planning, but this appears to be based on historic patterns of participation, which could suddenly and significantly change. We would therefore ask for evidence in the next round on how these assumptions are comparing to current outturn working patterns, and on the planning assumptions made for the implementation of the Working Time Directive.
- 1.30 On **retention**, there appears to be no evidence of unwelcome trends developing at the present time as far as HCHS staff are concerned. We welcome the Health Departments' various initiatives to support retention, as we view it as essential to retain and attract back as many doctors as possible, so as not to undermine recruitment gains. Retention must be a key priority for the Departments, given the time it takes to train doctors and dentists, the numbers of women joining and already working in the profession, and the challenging staffing targets set by the Health Departments. We were therefore glad to see the Department of Health's comment that it was not complacent. We would, for example, urge the Department to consider a programme of systematic exit interviews to gather evidence on why doctors and dentists are leaving the NHS. However, we do have some specific concerns this round about the retention (and recruitment) of GPs working within the GDS. We discuss this further in chapter 3.
- 1.31 On **motivation**, we were pleased to learn that the Department of Health's new national staff opinion survey was due to be introduced in October 2003. We have commented in previous reports on the need to establish a baseline from which to measure motivation on a consistent basis. We hope that the survey will provide evidence for our remit groups on the impact on their morale of new NHS developments, policy initiatives and workload, their overall job satisfaction and future commitment to the NHS. We look forward to receiving evidence on the results from the first survey in the next round. However, we were disappointed that once again this year, there was no new MCRG data on the future retirement intentions of HCHS doctors. As we have said before, intentions may not be a reliable indicator of future actions, but they are a useful indicator of current morale, particularly as results from the staff opinion survey are not available this year. The motivation of GPs working within the GDS is of concern to us this round and we discuss this in more detail in chapter 3.

- 1.32 *In its general remarks about the current round, the BMA said it would be wrong not to recognise that doctors in the remit groups whose contracts were not being renegotiated (including consultants opting to remain on the existing contract) were subject to the same **workload** pressures, and that their performance was being sustained at high levels or was improving without explicit financial incentive. The Department of Health has argued previously that the extra numbers of staff and the range of HR policies in the NHS Plan are the solution to the workload problem. Evidence presented by the Health Departments on the number of doctors working within the HCHS indicates that numbers are continuing to rise, but we have had no substantive evidence about the effect this may have had on workload. The BMA has provided us with the results of various surveys, but we suggest a joint effort with the Health Departments to provide a systematic evidence base. We commented last year that the increases in the medical workforce may have just soaked up the extra demand for NHS services. However, they may also have resulted in a reduction in the workload of the existing workforce. We would ask the parties, and the Health Departments in particular, to consider what evidence they can present to us for the next round to help clarify this issue for us. As with recruitment, retention and morale, we have some particular concerns about the workload of GPs which are discussed in more detail in chapter 3.*

Output targets for the delivery of services

- 1.33 The **Department of Health** noted that our last report had asked it to elaborate on how it saw output targets being brought to bear on our recommendations. This was a complex issue. The Department said it had not been able to address it fully given this year's compressed timetable, but would consider it for next year's evidence. However, progress against its Public Service Agreement (PSA) targets had been published in July 2003, and information on service improvement published in May 2003. The new planning framework for the NHS was designed to concentrate on fewer, more focused national targets and to provide greater flexibility at a local level to determine the pace for (some) target delivery.
- 1.34 The Department still did not believe it was possible to quantify in any precise way the impact which our recommendations on pay in one year would have had on the achievement of output targets in the next, nor would it be meaningful to attempt to do so, given the complex factors at play. Instead, it considered that output targets should be seen as part of the wider context within which we considered our recommendations. The targets were a crucial element of the Government's strategy for improving public services, as they provided a clear focus for planning and delivery, and for measuring the return on its unprecedented levels of investment. The Department said that moreover, the link between pay, including our recommendations, and output targets was multi-faceted:
- pay was only one factor in ensuring recruitment and retention, and the evidence showed that (generally) recruitment was healthy and other measures were being taken to maintain and improve this;
 - affordability and other cost pressures were crucial factors in considering the links between pay and output targets. Service improvements would not be delivered if the NHS's extra resources were diverted into unnecessarily large pay increases; and
 - there was a commitment to invest in improved pay for doctors and dentists, but this must be linked to pay modernisation and targeted action, rather than excessive general pay increases, to put in place the necessary flexibilities and incentives to deliver the service improvements required to meet the Government's output targets.

- 1.35 The **SEHD** described some of its objectives for health over the Spending Review period and said that targets for the medical and dental workforce had been set.
- 1.36 The **National Assembly for Wales** described the agenda and vision for health improvement set out in *Improving Health in Wales – A Plan for the NHS with its Partners*. The *Plan* was launched in February 2001 and was to be implemented over a five to ten year period. Derek Wanless, author of the report for the Chancellor of the Exchequer, *Securing our Future Health – Taking a Long Term View*, had also acted as advisor to a team set up to review health and social care in Wales. The review had been completed in June 2003 and had concluded that the current position in Wales was worse than the UK as a whole, reflecting trends evident over decades. The Assembly was currently developing an implementation plan to take forward the review's recommendations.
- 1.37 The **BMA** said it had noted our comments in our last report regarding the Health Departments' statements on output targets. It had said before that many of these targets were both long-term and outwith the capacity of doctors to deliver, and it was difficult to see how we would be able to relate progress (if any) to pay levels. Given that pay systems would increasingly link individual or practice income to quality criteria, our role should be to recognise overall workload and workforce changes, and to reflect these in pay.

Comment

- 1.38 *We note that the Department of Health has not been able to fully address the request in our previous report for the Health Departments to elaborate on how, in practice, they see output targets being brought to bear on our considerations, and that the Department intends to consider it for the next round. We would repeat the observations we made in the last report, as the Department has also made the same points about the context for considering output targets. We agree with the Department that pay is not the only factor in the recruitment and retention of staff needed to deliver output targets. However, it has a part to play in sending a positive message about the value of staff who are working in an environment where staffing targets have yet to be met for some groups. Staff are not the only resource required to meet output targets, but the targets will not be met without them. At least until the extra numbers coming into the medical workforce start to feed through into a demonstrable reduction in workload, we believe that retention is a very important factor, and that the Health Departments' output targets are more likely to be met if our recommendations take account of the current conditions under which our groups are working. This requires us to take a view of the risk posed to the achievement of the targets and how our pay recommendations might further affect any such risk.*
- 1.39 *As the Department of Health considers this issue further over the coming months, we would ask the Department to tell us clearly whether output targets are something other than affordability. As affordability is already covered by our remit, we would find it more helpful to have, for example, an assessment of how our recommendations from the previous year have helped (or hindered) the Health Departments to achieve their output targets, including the effect on productivity.*

The funds available to the Health Departments

- 1.40 The **Department of Health** stressed that pay awards must be set within a framework that considered:
- the spending limits set by the Chancellor in his Budget statement;
 - the Government's challenging plans against a range of output targets for delivery of services; and
 - the Government's inflation target of 2.5 per cent and the anticipated rate of inflation in the economy as a whole of 2.69 per cent in 2003-04, 2.59 per cent in 2004-05, and then 2.5 per cent in future years.
- 1.41 The Departmental Expenditure Limits (DELs) for 2002-03 until 2007-08 were set out showing cash growth of around ten per cent per annum and real terms growth of around seven per cent per annum. However, the Department stressed that these increases were not a benchmark for pay settlements. Average real terms growth in revenue funding (to fund pay, amongst other things) was 6.7 per cent over the five-year period to 2007-08, less than the overall average growth of 7.4 per cent real terms. The use of the overall DEL needed to be considered against the ongoing commitment to the modernisation of the NHS, and, in particular, the objectives set out in the *NHS Plan* and the impact of underlying demand pressures. These costs would include, among other things:
- delivery of *NHS Plan* and National Service Framework policy commitments and targets;
 - increasing demand for services supplied by GMPs, dentists and opticians;
 - year-on-year rises in demand for hospital services, shown by increases in emergency admissions and A&E attendances;
 - cost and demand for drugs, with pressure on the drugs bill of typically over 11 per cent;
 - cost of increasing staff numbers, training opportunities, and medical school places;
 - the three major programmes of NHS pay reform – *Agenda for Change*, the new consultant contract and the new GMS contract;
 - pressures arising from the implementation of the European Working Time Directive (EWTB) for doctors in training; and
 - resources for capital investment for new hospitals and equipment, IT infrastructure, and training and development for the growing NHS workforce.
- 1.42 The Department said that the period 2003-04 to 2007-08 would see the highest sustained increase in funding in the history of the NHS, but it was a fixed funding envelope with no extra resources to meet excess costs arising from pay settlements. It was crucial that pay increases were no more than the rate of inflation to ensure resources were available to deliver growth in capacity, service improvements and pay modernisation.

- 1.43 The constraints on affordability applied similarly to non-discretionary (i.e. demand-led) Family Health Services provided by independent contractors under the terms of their national contracts. The Department said that the more NHS resources were committed to meet contractors' pay, the less there would be available for service developments or to meet the pay costs of employed NHS staff.
- 1.44 The Department said that a responsible approach to pay was crucial if it was to achieve all the objectives in the *NHS Plan*. The commitment to modernisation and the range of additional costs pressures, including increased activity and expansion of the workforce in line with *NHS Plan* targets, meant there was significantly less money available than it might first seem. The Department said that affordable pay settlements were an essential part of delivering the agenda for improvements for patients and staff. The Government's commitment to keep public spending within the DELs and to invest in pay modernisation needed to be a key factor in determining pay in the coming year.
- 1.45 The **SEHD** said health services had seen a substantial and sustained injection of new resources, but staffing costs accounted for about 60 per cent of total expenditure, as there were proportionately more NHS staff in Scotland than England, and so the cost of implementing any given level of pay award was correspondingly higher. The level of any pay award should take account of the SEHD's total funding, the commitment to deliver key national priorities and modernisation of the NHS, the position of Scotland in relation to the new consultant contract, affordability and competing demands for new investment, and the Government's inflation target for the economy as a whole of 2.5 per cent. The funding provision for 2004-05 and 2005-06 showed cash growth of eight per cent and 8.9 per cent respectively, and real terms growth of 5.26 per cent and 6.26 per cent respectively. The SEHD stressed that these increases could not be seen as a benchmark for pay settlements, but must be considered against the commitment to modernisation and the impact of underlying demand pressures. The indicative revenue allocations for 2004-06 which had been notified to NHS Boards included increases ranging between 6.75 per cent and 8.48 per cent, with an average of 7.25 per cent. Similar levels of increase were also anticipated for 2005-06. The SEHD said that pay played an important part in NHS improvement, but it was only one element.
- 1.46 The **National Assembly for Wales** set out its DEL for Health until 2004-05, though the figures for that year were provisional. Cash growth for 2004-05 over 2003-04 was 7.5 per cent, with real terms growth of 4.7 per cent. However, we were asked to note that:
- unlike England, there had not been a five-year settlement for health;
 - the funding increase for health, though significant, was lower than in England;
 - the Assembly had a higher level of expenditure on NHS manpower than England;
 - the Assembly was committed to introducing pay modernisation for all groups of NHS staff, and had its own targets for growth of NHS staff in Wales;
 - Wales faced the same underlying demand pressures as England, and had relatively greater health needs; and
 - because of these factors, there was relatively less funding available as growth on revenue than England. Accordingly, Wales found it more difficult to fund pay awards than England.
- 1.47 The Assembly asked us to recognise that pay settlements must be affordable and that

affordability was more difficult in Wales than in England. However, the Assembly said it recognised the need to restore a more open and consultative approach to handling pay developments across the four UK Health Departments and for this reason it endorsed the main recommendations.

- 1.48 The **BMA's** evidence summarised proposed UK NHS spending over the period 2002-03 to 2007-08, noting that cash growth would be in the order of ten per cent per annum over this period, representing some 7.3 per cent per annum in real terms. The resources available within these sums to reward staff could be supplemented by efficiency gains. The BMA suggested that the Government quantify the extent of movement towards its cost benchmarks to enable us to take due account of this in making our recommendations.

Comment

- 1.49 *Once again this round, the parties offer very different interpretations of what can be done with the extra resources allocated to the NHS until 2007-08. The Health Departments stress the need to keep pay increases in line with the Government's inflation target, in view of the various demand-led cost pressures faced by the NHS and the Government's commitment to modernisation of the service within the current funding envelope. The BMA argues that the resources are available within these sums to reward staff. We appreciate that a careful balance needs to be struck between our pay recommendations and the overall resources available to the NHS. We also understand that there is a variety of demands on the resources available to the Health Departments. We must take account of affordability, in accordance with our terms of reference, and we must also exercise our judgement about what is necessary, as far as pay is concerned, to recruit, retain and motivate our remit groups. In due course, we also expect to have regard to the principle of equal pay for work of equal value, and to take account of evidence about legal obligations on the NHS, including anti-discrimination. As we said in our last report, in doing this, we seek to be fair to both the taxpayer and to our remit groups.*

Economic considerations and the Government's inflation target

- 1.50 The **Health Departments** said that average earnings growth had remained subdued. Data from Industrial Relations Services showed that for the whole economy, public and private sectors, median basic pay settlements over the 12 months to August 2003 were 3.0 per cent, 3.5 per cent and 3.0 per cent respectively. Data for the same period showed that the headline annual increase in public sector earnings for July 2003 was 5.1 per cent, which was higher than the equivalent increase for the private sector of 3.0 per cent. For the whole economy, the increase was 3.4 per cent.
- 1.51 The Departments said that the Government had set the Bank of England an inflation target of 2.5 per cent, as measured by RPIX (the Retail Prices Index, excluding mortgage interest payments), and the Bank had acted quickly and decisively to meet this target. Latest data on RPI and RPIX inflation from May 1998 to August 2003 showed that RPI inflation was 2.9 per cent over the 12 months to August 2003. The equivalent RPIX figure was also 2.9 per cent. The Bank of England's Inflation Report (August 2003) forecast RPIX inflation to fall steadily to below 2.5 per cent during the final quarter of 2003. The central projection was that inflation would then remain slightly below 2.5 per cent during 2004, before returning to the target towards the end of 2004. The Chancellor had announced the Government's intention to replace the current RPIX target with the Index of Consumer Prices (CPI), to be set in the next Pre-Budget Report³.

- 1.52 The **BMA** noted that both the RPI inflation rate and the Government's target rate of RPIX over the year to September were 2.8 per cent, down from 2.9 per cent in August. It quoted the National Institute for Economic and Social Research comment highlighting increases in oil prices and housing costs as having had a strong upward effect on the inflation indices. The BMA said these factors should exert less pressure during 2004 and a consequent fall in RPIX to approach the Government's target could be expected. The average of independent forecasts for RPIX inflation was 2.3 per cent for the fourth quarter of 2004, compared with an expected 2.6 per cent for the fourth quarter of 2003. Furthermore, the most recent Treasury survey of independent forecasts for the medium-term showed they expected RPIX to increase at an average of 2.2 per cent per annum between 2005 and 2007, so the prospects were for continuing low inflation over the whole period of the Government's NHS spending plans. The BMA said that NHS non-pay costs, as measured by the Health Service Cost Index, historically increased by less than RPI inflation.
- 1.53 Consequently, the BMA said it saw no reason to alter its view that a stable and low rate of inflation would persist and would benefit the NHS. It was disingenuous to argue that pay increases for doctors and dentists should do no more than match the predicted growth in prices, which would deny those staff a share in increasing national prosperity. Neither this argument, nor the fear of contributing to an upturn in inflation, should be used as an excuse to hold down remuneration.

Comment

- 1.54 *We have taken account of the economic evidence presented to us by the parties, and of the more recent data that has been published in the period since that evidence was submitted. We have had particular regard to indicators of rates of change such as inflation, average earnings and pay settlements. Since the summer, the annual growth rates of both RPI and RPIX have been in the range 2.5 per cent to 2.9 per cent. The data for the year to December puts the annual growth of these indices at 2.8 per cent and 2.6 per cent respectively⁴. Reflecting the low and stable inflation experienced by the economy, median pay settlements in the three months to December have been around 3.0 per cent to 3.2 per cent. This is similar to the situation we observed this time last year. According to pay commentators, the bulk of settlements have lain between 2.5 per cent and 3.5 per cent. Headline earnings growth in the whole economy was 3.4 per cent per annum for the three months including December, very similar to the rates seen over the preceding twelve months. Earnings growth in the public sector continued to exceed that in the private sector, the annual rates being 4.4 per cent and 3.2 per cent respectively.*
- 1.55 *We have taken careful note of the economic evidence put to us, but inflation, earnings and settlement data are only part of the evidence we need to consider. Our aim is to make balanced recommendations and we are exercising our judgement independently, taking due account of the risk of non-delivery of the service and judging against all the provisions of our terms of reference what is necessary, as far as pay is concerned, to deliver and retain adequate numbers of good quality, motivated staff.*

Regional and local variations in labour markets

- 1.56 In evidence on the general context for the round, the **Government** said that the public sector accounted for around a fifth of the overall economy and its functioning conditioned how effectively the rest of the economy operated. Improving the public sector's flexibility was therefore an essential element of economic policy, and pay and pay systems were a vital ingredient. Increased responsiveness to local circumstances and

needs was crucial to the aim of improving public services. The local and regional dimension was particularly important and the evidence was striking in suggesting that public sector pay showed much less differentiation by region than the private sector. This needed to be addressed, and where necessary, the Government had changed the remits of the Pay Review Bodies this year to give greater prominence to this issue.

- 1.57 However, the Government was not looking for a fundamental change of direction, which could be potentially disruptive, but rather an evolutionary but definite change, building on current structures. The Chancellor of the Exchequer had made clear that national pay determination would remain and this was fully consistent with building on existing mechanisms that encouraged local and regional responsiveness, such as those contained in *Agenda for Change*, or in the zoning arrangements within the Prison Service pay system. The Chancellor had announced a programme of work to publish data on regional price levels and inflation rates in order to help take proper account of regional and local factors in pay decisions.
- 1.58 In its specific evidence in relation to medical and dental staff, the **Department of Health** noted that we had been asked to have regard to regional and local labour markets and their effect on recruitment and retention. Historically, the only nationally agreed provision for regional variation in doctors' and dentists' pay had been the system of London weighting. The principal allowance in the London Zone for 2003-04 was £2,047 for non-resident staff and £570 for resident staff.
- 1.59 The new consultant contract included a provision for employers to pay a recruitment and retention premium of up to 30 per cent of starting salary, either as a single lump sum, or on a recurrent basis for a period not typically exceeding four years. Under the existing contract, there was provision for employers to re-advertise hard to fill posts at the top of the consultant scale. The Department said that three-month vacancy rates for medical and dental consultants suggested comparatively greater problems of recruitment and retention in a number of northern areas. There were also relatively high vacancy rates in South East London, Kent and Medway. These differences generally became much more pronounced for particular specialties, such as psychiatry and radiology, and there was also likely to be substantial variation in vacancies between Trusts within each Strategic Health Authority (SHA). Areas with the highest vacancies also, in most cases, had lower than average numbers of staff per 10,000 population, though South East London was an exception with the highest number of staff per head of population in England.
- 1.60 The Department said that a number of possible factors were likely to explain these variations, including the location of medical schools, opportunities for teaching, research and for additional work outside the NHS (e.g. in private practice), and consultants' preferences about where they wished to live. As consultant supply expanded and with the creation of new medical schools, the Department expected to see a reduction in the degree of variation between localities. Nonetheless, there was a need to investigate the reasons for current variations and assess whether greater differentiation in pay would contribute in a cost-efficient way to reducing comparative recruitment and retention pressures.

³ The Chancellor of the Exchequer subsequently wrote to us informing us of this change of target. He has set the Bank of England a new operational target for monetary policy of two per cent, as measured by the twelve month increase in the Consumer Price Index. We have noted this change but for the purposes of this review, as with other Review Bodies, we have continued for the purposes of this report to have regard to the existing measure, on which the evidence submitted to us has been based.

- 1.61 The Department said it was therefore proposing to work with other stakeholders to gather more detailed evidence on:
- the reasons for variations in staffing and vacancy levels between different localities, including analysis by specialty;
 - the extent to which NHS employers were already using pay or non-pay measures to address recruitment and retention problems, and the extent to which they used recruitment and retention premia under the new consultant contract; and
 - the effectiveness of such measures and their impact on the geographical distribution of consultants.
- 1.62 A more detailed assessment could then be made of the likely effectiveness and cost-effectiveness of greater pay differentiation in addressing comparative recruitment and retention difficulties. The Department said it would present evidence for our next round in 2004 and invited us to endorse its proposed programme of work.
- 1.63 The **SEHD** said it supported the proposals to improve evidence on the likely effectiveness of pay differentiation and non-pay measures in addressing regional variations in recruitment and retention. It would develop this evidence base as part of a project to increase the number of consultants by 600 over the period of the Spending Review.
- 1.64 The **National Assembly for Wales** said that it would not wish us to class Wales as a UK region as it could be vulnerable if we recommended differential pay increases to reflect regional price indices. The cost of living may well be cheaper in Wales than in London and the South East, but this was counter-balanced by massive problems in attracting people to work in hospitals in places such as Merthyr Tydfil and Haverfordwest. The Assembly would look at geographical and specialty variations in consultant vacancies across different parts of Wales and include the results as part of its evidence for next year. In the interim, it said it supported the view that national pay determination should remain.

Comment

- 1.65 *The Department of Health has invited us to endorse its proposed programme of work, to be taken forward in discussion with other stakeholders, to gather more detailed evidence on regional and local pay issues affecting our remit groups, in order to present evidence for our consideration in the next round. We welcome the Department's collaborative approach to this issue and endorse its proposals.*
- 1.66 *It may be helpful, at this early stage, if we feed in our views to the Health Departments on the kind of evidence base we would find helpful in order to be able to carry out our remit requirement to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of staff. We would start by observing that different considerations may well apply when considering regional/local variations in the labour markets of those of our remit groups who are independent contractors (GMPs and GDPs), rather than salaried employees. This will be something the parties will wish to consider as they take forward the proposed work programme.*

⁴ Since deciding on our recommendations, figures for the year to January have been published for both RPI and RPIX, of 2.6 and 2.4 per cent respectively.

1.67 *The examples of information on local labour market conditions and recruitment and retention which are set out in the Treasury's Guidance on Local Pay⁵ seem to us to form a helpful starting point. Our suggestions below are therefore largely drawn from this Treasury guidance:*

- *vacancy rates and recruitment difficulties and their composition (i.e. locality, skill base, specific grades);*
- *assessment of whether quality of staff appointed varies by location or whether grades are being used differentially in order to match pay to market conditions;*
- *wider labour market indicators, such as unemployment rates and regional price indices;*
- *retention problems, whether they can be attributed to specific areas and whether they are related to pay or other factors, such as work tasks, culture of leadership;*
- *whether the current package of benefits offered by the organisation is sufficient or excessive, and the degree to which non-pay factors can influence staff turnover rates;*
- *the staffing profile (such as age, gender and ethnicity) and whether this addresses diversity requirements of the organisation;*
- *exit interview information on reasons for leaving and next destinations;*
- *information from staff surveys on perceptions of reward adequacy in different locations; and*
- *differences in productivity between SHAs.*

1.68 *Not all of these indicators will be relevant to our remit groups, for example, the market for consultants can be argued to be national rather than local, many of our remit groups are self-employed, and local unemployment rates may not be relevant unless they influence medical or dental staff's wider considerations about an area. We know that Trusts already have a certain flexibility in using the national pay structure to tackle recruitment and retention difficulties and we would find it helpful to see some representative case studies looking at measures which have been used by a range of Trusts to deal with recruitment and retention problems.*

1.69 *In considering any case for pay action to address recruitment and retention difficulties at the individual Trust level, we would also expect to see evidence that management problems were not the underlying cause. The Treasury's guidance touches on this in suggesting that information would be needed on retention problems that might be related to factors such as culture or leadership. We would also suggest that evidence of HR actions already taken by employers of our remit groups to deal with labour market difficulties, would be helpful. Such information might include evidence of:*

- *instituting efficient leadership with clear management structures within the Trust, and carrying out effective personnel practices;*
- *provision and encouragement for continuing professional development;*
- *measures taken to improve the work/life balance of staff;*

⁵ *Guidance Note on Progressing Local Pay, HM Treasury, October 2003*

- *measures taken to allow staff to focus on teaching/learning duties;*
- *non-pay benefits; and*
- *measures taken to deal with any environmental problems.*

- 1.70 *If hard statistical data, such as vacancies and turnover, are considered alongside HR management data, it should avoid a situation arising where poor management was unfairly rewarded when a case for additional funding to tackle a persistent recruitment or retention problem was being considered.*
- 1.71 *We hope that these suggestions are useful to the Department of Health as it takes forward its work programmes, and we would ask the Department to keep our secretariat informed of and involved with developments. We would ask the Scottish Executive Health Department to keep our suggestions in mind and also to keep our secretariat informed of developments with its own work programme. For the next round, we would ask the National Assembly for Wales how it intends to approach this new aspect of our remit.*
- 1.72 *We would also remind all the Departments that evidence on regional/local pay should cover all medical and dental grades, and not just consultants.*

London weighting

- 1.73 The **BMA** said that the revision of our remit to include regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists placed the issue of London weighting within our remit. From the vacancy data for all medical and dental staff in England by SHA (also broken down by specialty for consultants), the BMA said it had concluded that there was no relative vacancy problem associated with London for employed staff. However, there was a case for cost compensation in the interests of equity and, the BMA considered, it was also inappropriate for doctors and dentists to be treated less favourably than other NHS staff. London weighting for our remit groups was currently calculated as a weighted average of the Inner and Outer London rates payable to other non-nursing NHS staff (44 per cent and 56 per cent respectively). This was designed to reflect the proportions of medical and dental staff working in these zones.
- 1.74 The earnings related component of the nursing and allied professions' allowance (five per cent of salary capped at £750) had recently been consolidated into the general London Allowance, making it a pure cost compensation payment, designed to rise in line with the overall award. From 1 April 2004, the Inner and Outer London Allowances for these staff would increase to £3,441 and £2,688 respectively. If the historical proportions used to calculate the Medical and Dental Staff allowance were applied to these figures, the BMA said there would be an implied London Allowance of £3,019, as compared with the current £2,047.
- 1.75 The BMA noted that the formula used to distribute revenue to health authorities included a market forces factor (MFF) to correct for unavoidable cost differences between health authority areas and it considered this could be regarded as a proxy for the excess costs met by London doctors. The average for the 16 London health authorities was 116, i.e. costs were on average 16 per cent higher than the English average. The BMA also noted that the Greater London Assembly's (GLA) scrutiny of London weighting had concluded that a London Premium should compensate wage differentials, as calculated by comparison with the private sector, and that the appropriate differentials were 33 per cent for Inner London and 11 per cent for Outer London. The average for Greater London was 22 per cent.

- 1.76 The BMA said that the *Agenda for Change* agreement for the NHS also included specific pay provisions for staff working in high cost areas and these payments were distinct from those needed to address recruitment and retention pressures. It said that *Agenda for Change* conceded that the initial focus would be on the London area, but could in principle be applied to other high cost areas. The BMA said this reinforced its own argument that the payments constituted cost compensation. *Agenda for Change* allowances would be a proportion of basic pay, subject to minimum and maximum levels. For Inner London, the allowance would be 20 per cent, subject to a maximum of £5,161 and minimum of £3,097. For Outer London, the percentage would be 15 per cent, with a maximum of £3,613 and a minimum of £2,581. Translating the maximum values using the existing percentage formula for salaried medical and dental staff would give London weighting of £4,294. On the basis of its analysis, the BMA concluded that London weighting should be increased from 1 April 2004 to at least £5,000.
- 1.77 The BMA also commented that London weighting was a particular issue for consultants who were more likely to remain at one hospital for a major part of their career (unlike junior doctors). Consultants were also expected to live within a certain radius of their base hospital and so there was a cost compensation case in the interests of equity.
- 1.78 The **Department of Health** said that the average number of consultants per 10,000 population in England was 5.5, and consultant numbers in four of the five London SHA areas were above this mean and were also the four highest in England. The mean three-month vacancy rate for consultants in England was 4.7 per cent, but in four of the five London SHA areas the percentage was significantly below the mean. South East London had a higher vacancy rate (6.0 per cent), but it also had the highest number of consultants by weighted population. This evidence strongly suggested that NHS Trusts in London generally found it easier to attract doctors than most other areas of the country. The Department considered that the comparatively greater recruitment problems of areas outside London suggested there was weak justification (if any) for the existence of London weighting. As part of its proposed programme of work, the Department intended to investigate the factors affecting London more fully. In the meantime, it saw no case for any increase in London weighting and sought our agreement that for 2004-05 it should remain at its current value in cash terms.
- 1.79 For staff covered by the new *Agenda for Change* pay system (which included the remit groups covered by the Pay Review Body for Nurses and Other Health Professions), the new 'high cost area' supplement being introduced for London and the Fringe would vary according to basic salary – up to a maximum of £5,161 at 2003-04 pay levels in Inner London, £3,613 in Outer London and £1,342 in Fringe areas. These higher levels of London supplements for these staff groups were justified by the very different nature of the labour market for most NHS staff groups, compared with medical and dental staff, and its reflection in recruitment and retention problems. In particular:
- for these groups, the NHS was competing with external labour markets for staff, whereas the NHS was the dominant employer of doctors;
 - higher pay levels for non-medical staff in London was likely to attract people back to the NHS workforce, but there was no evidence to suggest a significant potential pool of returners to the medical workforce;
 - differentials between public and private sector pay were markedly higher in London than elsewhere and this appeared to be one of the main factors driving recruitment and retention problems across London for the *Agenda for Change* groups. Vacancy levels for nursing and allied health professional staff were higher than the national average in all the London SHAs; and

- a common level of supplement for non-medical staff in London helped to reduce the risk of wage spirals and excessive turnover.

- 1.80 In supplementary written evidence, the Department of Health said that under the old consultant contract, consultants were required to reside within a distance of ten miles by road from their base hospital unless they had the approval of their employing organisation to reside at a greater distance. The new contract required consultants to reside within a distance of 30 minutes or ten miles by road unless the employing organisation agreed that they might reside at a greater distance. It said that despite this requirement, NHS Trusts in London found it easier to attract doctors than most other areas of the country. The Department said that it did not accept there was a case for London weighting to be increased, and that if anything, the evidence suggested it should be phased out altogether, but it would provide more detailed evidence on this for the next round.
- 1.81 In supplementary written evidence, the **BMA** noted that the Department had commented that because there appeared to be no relative vacancy problem for consultants in London, London weighting should be phased out altogether. It said that this was because the Department believed that London weighting was in place purely to address potential recruitment problems, but it said that London weighting was originally in existence for reasons of cost compensation.

Comment

- 1.82 *The parties agree that the available data on relative vacancies in London for consultants indicates that there are no problems with recruitment. We note here that we are only presented with data on consultants and so have no evidence on which to reach a view at this stage about possible labour market difficulties for our other remit groups. We have already referred in our earlier commentary on developing an evidence base for considering regional/local pay about the need for data to cover all our remit groups, and we would ask the Department of Health to look at this specifically with regard to London weighting for the next review.*
- 1.83 *As there seems to be no case for action on the grounds of labour market difficulties for consultants, we have considered whether looking at London weighting on cost compensation grounds still lies within our remit. We consider that as it is a pay issue and the parties have both referred the matter to us, that we should consider the BMA's request.*
- 1.84 *We note firstly that not all our remit groups receive London weighting, which we find puzzling, and would ask the parties, and particularly the Department of Health, for further evidence for the next round on why this is the case. Our recommendations this round will therefore apply to hospital medical and dental staff, doctors in public health and the community health services, salaried GMPs and GMP registrars, and to salaried GDPs and dentists working in the Community Dental Services. Our recommendations will not apply to GMPs working within the GMS or to GDPs working within the GDS. We comment further on the position with regard to GDPs in chapter 3.*
- 1.85 *The BMA has asked us to recommend that London weighting is increased from its current level of £2,047 to £5,000 per annum, on the grounds of cost compensation in the interests of equity with other NHS staff. Although the BMA has cited the arrangements for high cost area supplements under Agenda for Change in support of its case, it has not advanced any detailed arguments as to why it is seeking the precise figure of £5,000. We would ask the BMA to provide such evidence in the future in support of a specific pay proposal.*

- 1.86 *On the basis of the evidence presented by the Department of Health this round, which only considers consultants and none of our other groups who receive London weighting, we do not consider that we are in a position to do more than recommend a general pay uplift to London weighting for 2004-05. We therefore **recommend** (recommendation 1) that London weighting is increased in 2004-05 by 2.5 per cent, in line with the Government's inflation target. The detail of our recommendation is set out at Appendix A and we estimate that this may cost something in the region of £800,000 in 2004-05. We will consider the matter further next round, when we hope that the Department of Health is able to present us with further evidence.*
- 1.87 *We note the Department of Health's view that London weighting should remain at its current value in cash terms, on the basis of its data for consultants, but we do not consider that such a recommendation is appropriate when we have no data about the position for our other remit groups. As we intend to consider the need for and, if appropriate, the level of London weighting (and how it should be updated) on both a labour market basis and a cost compensation basis, we will consider the Department's argument that there is no case for increasing London weighting in the light of further and better evidence.*
- 1.88 *We would also ask the Department of Health to consider whether equal value might be a relevant issue for our considerations, and to present evidence on this for the next round.*

Pay comparability

- 1.89 The **BMA** noted the conclusion in our previous report that the remuneration of our remit groups remained broadly in line with that of comparators. It considered this was contentious and intended to conduct a major exercise looking at comparative remuneration over the coming year to present relevant evidence for the next round. For now, it considered that the available evidence suggested that differentials continued to widen, with those at the higher end of the earnings spectrum consistently receiving increases in excess of the average.
- 1.90 Last year the BMA said it had quoted research used in the interim report from the Wanless enquiry which showed that the pay of career grade doctors had declined from the 94th to the 90th percentile of the earnings distribution since 1980-84. It said that we had not been convinced of the general case for a substantial increase to reflect comparator pay, but we had conceded a decline in the relative position of consultants against comparators during the last five years. Junior doctors were now particularly concerned that pay progression was more rapid in other professions.
- 1.91 The BMA said that settlement levels had been rising steadily throughout 2003 and now averaged three per cent overall (3.5 per cent in the public sector). The trend for public sector settlements to exceed those in the private sector had been a consistent one over the last two years, indicating an acceptance by public sector employers of the need for a relative adjustment of public sector pay levels against private sector equivalents. The BMA said that this trend in settlements was echoed in overall earnings movements, with average earnings in the public sector rising at 5.1 per cent as compared with 3.4 per cent for the economy as a whole. The BMA considered that the overall decline in the rate of increase of average earnings in the face of an increase in settlement size probably reflected the continued negative impact of private sector bonuses.

- 1.92 However, the BMA said that the prospect for earnings movements during 2004 was for growth to pick up slowly. The rate of increase of average earnings was expected to reach four per cent by the fourth quarter of 2004. The 2003 New Earnings Survey had departed from its predecessors by no longer analysing separately movements in manual and non-manual earnings and so the BMA's preferred indicator for the distribution of earnings was no longer available. However, over the period 1993 to 2002, movements in earnings of non-manual male employees were consistently towards increasing differentials. Ignoring contractual changes for consultants and GMPs, the BMA said that it again expected that pay increases of less than five per cent during 2004 would lead to a relative decline in medical earnings against comparators.
- 1.93 The **GDPA** said that it did not know with whom we had compared GDPs for the purposes of our last report, but considered that the proper comparator for NHS GDPs should in fact be dentists in private practice.

Comment

- 1.94 *As we have said in previous years, we consider that pay comparability is a relevant factor in our deliberations and so we make our own assessment of how the pay of our remit groups compares with that of other professions, both in terms of pay movements over recent years and of pay levels. Pay comparability is an important consideration in responding to recruitment and retention difficulties among our remit groups. We remain of the view that private and public sector comparators are appropriate and we continue to use solicitors, actuaries, chartered engineers, accountants, taxation professionals, and architects in both the private and public sectors. From the public sector, we use senior civil servants, members of the armed forces and university academics. In selecting these comparators we have due regard to the following criteria: similar entry requirements, training qualifications, and intellectual rigour. These are careers that might reasonably be thought of as possible alternative careers by individuals joining the medical and dental professions, and that have clearly defined career progression. We have also looked at recent trends in pay movements across the economy and believe that our recommendations have broadly kept pace with these in recent years.*
- 1.95 *This year consultants across England, Scotland and Wales have access to a new contract and we note that the remuneration of those consultants on the new contract appears to compare favourably with that of the comparator groups. For those consultants opting to remain on the old contract, and for the other medical staff in our remit, we note that the remuneration remains broadly in line with that of the comparator groups, although the remuneration of consultants on the old contract does appear to have drifted downwards over recent years. Given the increase in earnings offered by the new consultant contract, this raises the question as to why consultants should choose to remain on the old contract. We therefore request data in the next round on the number of consultants on the old contract by nature of contract and pay point in order to inform our views about this particular group.*

Longer term pay deals

- 1.96 The **BMA** reminded us of the ten per cent pay uplift over three years incorporated into both the new consultant and GMP contracts. The BMA said that these proposals had been made in order to bring forward funds to help meet the cost of the framework, and did not represent an estimate of the value of our recommendations over the period. The uplift therefore had no relevance to our recommendations for other remit groups⁶.

⁶ See paragraph 7.62 for the Department of Health's response.

Recommendations for 2004-05

1.97 The **Department of Health** said that with the exception of consultants on the new contract, GMPs within GMS, and salaried dentists, it was seeking pay increases at 2.5 per cent for 2004-05 for all other groups within our remit, in line with the Government's inflation target. This reflected:

- NHS expenditure limits from 2004-05 to 2007-08, the importance of ensuring stability in service and financial planning, and the critical importance of devoting the necessary funding to delivering planned improvements, increasing capacity and meeting demand-led pressures;
- the need to justify above-inflation increases by reference to benefits for service capacity and NHS patients (such as the principles of consultant contract reform); and
- the continuing increases in the numbers of doctors and dentists.

1.98 The **SEHD** said it endorsed the view that we should recommend increases at 2.5 per cent for all groups, except salaried dental services and consultants on the new contract. The **National Assembly for Wales** said is also endorsed this recommendation.

1.99 The **BMA** considered that those remit groups who were not covered by long-term agreements bound up in contractual change would need to receive a minimum increase in pay rates of five per cent from 1 April 2004, if they were to avoid losing ground against comparators. To the extent that these groups were exposed to the same workload and pressures as those groups covered by long-term agreements, the BMA said that it would be inequitable to deny them access to appropriate levels of remuneration on the grounds that they had yet to negotiate major contractual change. The BMA acknowledged that some element of the increases under the long-term agreements related to changes in working practices and productivity increases, which might in the future be negotiated with the remaining remit groups. However, the BMA invited us to exercise our judgement in recommending pay increases within the range five to 15 per cent, which the BMA considered would represent a fair level of increase.

1.100 In its evidence, the **NHS Confederation** recommended to us that the general pay award for remit staff (excluding GMPs) should cover two years at 3.225 per cent per annum for 2004-05 and 2005-06, similar to that available to consultants on the new contract. It said that differential recommendations would have a divisive effect in industrial relations terms. It said that we should not recommend any other changes to the pay system.

Comment

1.101 *We have considered carefully all the evidence from the parties who have urged us towards very different conclusions again this year. In reaching our decisions, we have sought to be fair to both the taxpayer and to the remit groups alike. The detail of our recommended pay increases for 2004-05 for the remit groups on which we are required to recommend this round is set out in the following chapters.*

Part II: Primary Care

CHAPTER 2: GENERAL MEDICAL PRACTITIONERS

2.1 *Although general medical practitioners (GMPs) are covered by the provisions of the new General Medical Services (GMS) contract, which means we are not required to make recommendations on remuneration of independent contractor GMPs for 2004-05 or 2005-06, several matters have been brought to our attention this round relating to GMPs which lie outside the main contract. These include the salary range for salaried GMPs employed by a Primary Care Organisation (PCO), the pay supplement for GMP registrars, GMP educators and trainers, GMP/clinical assistants working in community hospitals, GMP clinical assistants and hospital practitioners not working in community hospitals, Personal Medical Services (PMS), and sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities. We consider these various issues below, after the summaries of the parties' evidence.*

Evidence for the current Review

2.2 The **Department of Health** said it was submitting evidence on salaried GMPs employed by a PCO and on GMP registrars. Following acceptance by GMPs of the new GMS contract, the **Health Departments** said we were not required to make recommendations on independent contractor GMP remuneration for 2004-05 or 2005-06.

2.3 The **British Medical Association** (BMA) said that although its evidence on GMPs had not been seen or agreed to by either the NHS Confederation or the Health Departments, it intended to seek a common approach between the parties on the GMP issues it was raising, which it would then submit as supplementary evidence. It also intended to submit information on the revised role of the Technical Steering Committee (TSC) in relation to the new GMS contract, which it hoped to agree with the other parties. The BMA said it believed this was important, not least because information provided by the TSC on the new GMS contract would help to inform our deliberations on recommendations for salaried GMPs.

Comment

2.4 *We note that we are not required to make recommendations on independent contractor GMP remuneration for either 2004-05 or 2005-06, following acceptance by GMPs of the new GMS contract.*

Progress on implementing the new GMS contract

2.5 *The British Medical Association, the NHS Confederation and the Department of Health jointly wrote to us to describe progress on implementing the new GMS contract. A copy of the letter is at Appendix F. We note and very much welcome the progress that has been made between the parties to facilitate the implementation of the new GMS contract from 1 April 2004, and look forward to hearing of further developments for our next review.*

Recruitment and retention

2.6 The **Department of Health** said that there had been an increase of 800 GMPs (excluding GMP retainers and GMP registrars) between September 2002 and June 2003, compared to an increase of 400 during the year to September 2002. The Department also commented that GMP targets were in place which had to be reached by March

2004 and it said it was on track to meet the challenging target set out in the *NHS Plan*. It considered that recruitment, retention and return policies were working, but recognised, as with hospital doctors, that there was no room for complacency.

- 2.7 The Department said that the *Improving Working Lives* initiative remained a key recruitment and retention tool. The Government had also committed a further £100 million to extend the NHS Childcare Strategy to meet the childcare needs of all staff, including GMPs and GMP registrars. The Flexible Careers Scheme (FCS) for hospital doctors had been extended to GMPs with a very positive response – 368 GMPs were either in a FCS post or about to take one up across 127 Primary Care Trusts (PCTs). The Department said there was now a flexible retirement package for GMPs, providing a financial incentive of £2,000 for each year a GMP worked between 60 and 64.
- 2.8 In its evidence, the **BMA** noted that growth amongst GMPs continued to be disappointing at only 1.6 per cent this year (1.4 per cent last year), but an encouraging sign was the continuing recovery in the number of GMP registrars. Although the number of GMS unrestricted principals and their PMS equivalents increased by 188 in the year to September 2002 in headcount terms, expressed in “whole-time equivalents”¹ this fell to only 29. Comparing these increases to those promised in the *NHS Plan* for England, the BMA commented that progress continued to be disappointing as the *Plan* had promised an increase of 2,000 GMPs by 2004, equivalent to 400 a year from the base year of 1999. However, growth in GMS principals and their PMS equivalents had been disappointing, the BMA said, totalling only 440 since 1999, and short of the theoretical figure of 1,200. Even if the definition of GMPs was widened to include all non-registrars, the BMA said that growth since 1999 had still only totalled 735.

Comment

- 2.9 *We note the Department of Health’s evidence that the increase in the number of GMPs between September 2002 and June 2003 was double the increase in the 12 months to September 2002. However, we also note the BMA’s evidence about the slow progress against the NHS Plan target to have an additional 2,000 GMPs in place by March 2004. We will know, by the time we receive evidence for the next round, whether the Department’s confidence that it is on track to meet this target was well founded. Like the BMA, we are also encouraged by the continuing increase in GMP registrar numbers and hope that these doctors will go on to enter general practice, once their training is completed. We would ask the Health Departments to monitor the numbers of doctors entering into general practice after the completion of their training and to investigate why doctors choose not to do so.*

Salaried GMPs employed by a PCO

- 2.10 The **Department of Health** said that we had previously recommended a salary range of £46,455 to £70,710 for this group, with progression and review to be determined locally (now in place). We had asked for evidence on the use of the salary range and the Department understood that the BMA was conducting a survey of salaried GMPs’ pay and terms and conditions of service. We had also asked for evidence on the recruitment and retention situation for this group, but the Department said that the construction of the workforce census did not provide this. Instead, PCTs were required to report on the total numbers of GMPs within their areas. Between September 2002 and June 2003, the Department noted that there was greater growth in GMP numbers than during any previous 12 month period, but these data were not broken down by the source of the GMP. For 2004-05, the Departments asked us to uprate the salary range by 2.5 per cent.

¹ The BMA said the Department of Health calculated this using results from the 1992-93 GMP workload survey.

- 2.11 In its evidence, the **BMA** said that this group of GMPs were an essential and increasing part of the GMP workforce, with 1,085 salaried GMPs working in England at September 2002. The BMA considered that the uplift for 2004-05 should take into account the comparison between salaried GMPs and GMP principals, as there should be no financial disincentive to changing contractual status. Flexibility must be maximised for recruitment and retention purposes. The BMA said that many salaried GMPs worked in deprived and under-doctored areas where PCOs found it difficult to attract GMP principals. It was therefore vital to incentivise appropriately salaried doctors to undertake such work. In support of its arguments, the BMA provided a number of recent job advertisements for salaried GMP posts across the country which offered salaries in excess of the current salary range.
- 2.12 The BMA reminded us that the current pay scale for salaried GMPs was linked to that of hospital doctors and ran from the mid-point of the associate specialists' salary to the top of the consultants' scale. It therefore urged us to take account of both the significant uplift for consultants and appropriate pay comparability with GMP principals when making our recommendation.
- 2.13 The BMA said it would also greatly welcome our support for its position on the following issues:
- funding for the equivalent of seniority payments to be held at PCO level to make salaried posts attractive to GMP principals looking to lessen their practice commitment, and who might otherwise retire;
 - giving a steer to employers that incorporating elements such as incremental points and equivalents to seniority payments was important for recruitment and retention; and
 - funding for maternity, sickness, special leave, redundancy payments, and leave for professional development should be held at PCO level. The BMA said that practices needed financial support from PCOs to support the employment rights of salaried GMPs and other staff, or it would deter practices from employing salaried GMPs.
- 2.14 In supplementary evidence, the **Department of Health** said that the roles of salaried GMPs and GMP principals were potentially very different, and it saw no case for comparability between the two groups. It said that the option of working on a salaried basis was also new and there were no data as yet on how the new salary range was being used or what the new GMS contract would mean for the net profit of the average GMP principal. The Department said that the top of the original salary range, agreed with the NHS Confederation and the BMA in May 2003, was close to the top of the incremental range for consultants, as it then stood. However, this did not mean, the Department said, that it regarded the pay thresholds for consultants employed on the new contract as being an appropriate revised comparison. These new thresholds were linked to demonstrating a range of new criteria for performance and commitment, and were part of an investment-for-reform package designed to achieve fundamental reforms in the way that consultant services were managed. The Department stressed that the agreed salary range for GMPs was designed to be wide enough to cover the range of possible roles that salaried GMPs might be required to undertake, and it said it had no evidence to suggest that this was no longer the case.

- 2.15 In supplementary written evidence, the **BMA** said that the assertion that the roles of salaried GMPs and GMP principals were potentially very different and therefore presented no case for comparison was unacceptable. It said that in many respects, both salaried GMPs and GMP principals assumed similar roles within a practice. GMPs, irrespective of contractual status, offered a wide range of services to their patients. Being salaried did not mean that those clinical services were curtailed. Services provided might include family planning and minor surgery as well as child health surveillance and obstetric care. It said there were salaried GMPs who had undergone or were currently undergoing higher specialist training in a range of specialties, such as genitourinary medicine, emergency care and diabetic medicine. Some salaried GMPs also had roles as educationalists, GP tutors, teachers, mentors and appraisers. It said that all GMPs would undergo appraisal and be revalidated. To practise up-to-date integrated care that offered the best service to the patient required the GMP, irrespective of contract status, to be aware of administrative changes that could affect the practice. It said that practices that offered a high standard of care necessarily operated as a team and all GMPs within a practice would work together to attain and maintain those standards.
- 2.16 The BMA said that within the profession, a GMP could not achieve status or career advancement without accreditation, and career development was invariably achieved by working within the NHS. It said that in effect, the NHS operated a monopoly. To suggest that the contractual status of the GMP would influence the GMP's role within the NHS to the extent that a salaried GMP would adopt an incomparable role was erroneous and insulted the professionalism of the salaried GMP. It said that the salaried option was not new, and had been previously adopted mainly by women GMPs. It said that the model contracts for a salaried GMP employed by a PCT and a salaried GMP employed by a practice would require a change of thinking about employed GMPs and increased opportunities for salaried service for those GMPs who wanted them.

Comment

- 2.17 *The salary range for salaried GMPs employed by a PCO has been in place for less than a year and the parties have been unable to provide us with any substantive evidence for this round on its use or on the recruitment and retention situation for this group, as we requested in our last report. We note the information provided by the BMA which indicates that some of these posts are being advertised at salaries in excess of the top of the current salary range. This appears to indicate that some employers are using the flexibilities agreed by the parties to offer terms and conditions in excess of the agreed minimum, and for employers to use their discretion in determining salary to take account of a range of factors such as local job market requirements. We would want to see more substantive evidence from the parties about use of the salary range, and on recruitment and retention, before considering whether the salary range is no longer wide enough to meet general needs. We would ask the parties again for evidence that we can consider in the next round on the use of the salary range, and on the recruitment and retention of this group of doctors. We would also ask the parties for evidence on what use is being made of job evaluation to assign GMPs to a particular point in the salary range, as this was a part of the arrangements agreed between the parties last year, and in particular, whether job evaluation is being used where posts are being advertised at rates higher than the current range. We discussed in chapter 1 the types of evidence which might be useful in considering whether regional or local labour market variations are affecting recruitment and retention. Such evidence should help the parties to demonstrate that there was a need to extend the salary range to cover recruitment and retention difficulties in particular areas.*

- 2.18 *The BMA has proposed that the top of the salary range should now be aligned to the top of the new consultant payscale. The parties appear to have made no provision in last year's joint agreement for any realignment if the new consultant contract were to be introduced in the future. For the reasons given in paragraph 2.17, we consider that it would be premature to make any significant adjustment to the salary range at this stage. However, we consider that in the longer term, the top point of the old consultant contract may be an inappropriate linkage. Consultants who choose to remain on the old contract will be doing so for a variety of personal reasons and it may well be inappropriate to tie the remuneration of salaried GMPs to the personal decisions of some consultants. We would ask the Health Departments to consider this point carefully for the next round.*
- 2.19 *The BMA also proposed an uplift to the top of the salary range to take account of comparability with GMP principals, arguing that there should be no inappropriate financial disincentives to changing contractual status. We note again here that the national terms and conditions agreed by the parties last year were a minimum which PCOs and GMP practices would use as the basis of their employment of salaried GMPs, and that employers were given the flexibility to use their discretion to determine an appropriate salary by taking into account factors such as time spent working as a GMP principal. As there is no evidence at the moment to indicate that the current salary range is deterring GMP principals from switching to a salaried post, we consider there is no case for action, although we would ask the parties to keep this under review. In keeping with the parties' original agreement to set the bottom point of the salary range by reference to the associate specialist payscale and the top point of the range by reference to the old consultant contract, we therefore recommend (recommendation 2) that for 2004-05, the bottom point of the current salary range for salaried GMPs employed by a PCO should be increased by the percentage uplift figure for associate specialists (see chapter 8) and that the top point should be increased by the percentage uplift figure for consultants on the old contract (pre-2003 – see chapter 7). The salary range for 2004-05 will therefore be £47,710 to £72,478.*
- 2.20 *The BMA has also sought our support for its position on a number of other funding issues. With regard to funding being held at PCO level for the equivalent of seniority payments, we have already noted that it was agreed last year that employers could use their discretion in determining salary to take account of a range of factors, which included time spent working as a GMP principal. This suggests that if a GMP principal is considering switching to a salaried post, the employer can take the GMP's experience into account in agreeing a salary. Once again, however, we would welcome further evidence for the next round on whether this issue is causing any widespread recruitment or retention difficulties.*
- 2.21 *The BMA also highlighted that salaried GMPs have had difficulty negotiating incremental scales as part of their pay arrangements. We note here that the parties jointly agreed in their evidence for the last round that no recommendation was being sought from us on progression up the salary range, beyond support for this to be determined locally. We have had no substantive evidence for this round to indicate that lack of progression is now causing widespread difficulties, but would ask for further evidence on the use of pay progression for our consideration in the next round.*
- 2.22 *Finally, the BMA has suggested that funding should be held at PCO level for maternity, sickness, special leave and redundancy payments, and for leave for continuing professional development. The concern here seems to be focused on practices employing salaried GMPs, as the BMA believes that it is inappropriate for practices to be expected to risk manage these matters at practice level. The funding arrangements for practices working in GMS were agreed between the parties as part of the negotiations on the new GMS contract. These funding arrangements have been agreed for the initial three years of the contract. We therefore take no view at this time on the BMA's proposition, particularly as we have seen no evidence in support of the BMA's claim that this funding issue is putting doctors off pursuing*

a career as a salaried GMP, and that it will deter practices from employing salaried GMPs because of the financial risk. However, we would be interested in receiving any evidence in the next round on whether this issue is causing any widespread recruitment or retention difficulties.

GMP registrars

- 2.23 The **BMA** said it welcomed our previous recommendation to increase the GMP registrars' supplement to 65 per cent, but noted that 69 per cent of junior hospital doctors remained on the two higher pay bands as at March 2003 – Band 2A attracted a supplement of 80 per cent and Band 3 a supplement of 100 per cent. Transferring to a GMP registrar post was said to be still less financially attractive than remaining in a hospital post and this was accentuated in high cost areas (which could also be areas where recruitment was difficult), and the income fall might dissuade a trainee from entering general practice. As a high proportion of GMP registrars tended to stay in the area where they trained, the BMA said that an improved salary would help incentivise a move to general practice. The BMA therefore asked us to recommend that the pay supplement for GMP registrars be increased to 80 per cent of their basic salary.
- 2.24 The BMA reported that a number of other issues affecting recruitment and retention remained outstanding, due, it claimed, to lack of action by the Health Departments. We were asked to take these issues into account when determining the pay award for GMP registrars:
- the need to provide salary protection for certain groups of doctors transferring to general practice – non-consultant career grades, military posts, public health, university employees, Medical Research Council employees, doctors in other *bona fide* research posts, doctors working for the NHS in "other" capacities, for example employed by Deaneries, and doctors transferring from the community grades;
 - the disparity between pay for doctors working less than full time in hospital and in GMP registrar jobs (flexible trainees);
 - the lack of an annual uplift to the motor vehicle allowance since 1999;
 - excess rent allowances for single, married and cohabiting GMP registrars; and
 - sick leave arrangements for GMP registrars.
- 2.25 The **Department of Health** reported that since 1997, GMP registrar numbers had increased by 814 (60 per cent), bringing the total number to 2,157 in June 2003 – the highest number ever recorded. The Department said that numbers were expected to grow further. Following the recommendations in our last report, the Department said it saw no reason for any increases above the target rate of inflation (2.5 per cent) for GMP registrar salaries in 2004-05. The Department also reported that changes had now been made to the General Practitioner Registrar Directions to remove the pay anomaly whereby certain groups of doctors faced a drop in salary when they became a GMP registrar. The provisions for paying excess rent to GMP registrars had been amended to bring parity for single and married GMP registrars and equal treatment with other NHS staff.
- 2.26 In supplementary evidence, the Department said that of the junior hospital doctors in compliant posts, although 56 per cent were in Band 2A and received an 80 per cent supplement, the remainder were in lower, and some in considerably lower, bands. Overall, the Department said that hospital trainees in compliant posts received an average supplement of 66 per cent. This was said to be comparable to the supplement

currently paid to GMP registrars, and which was also paid to house officers in general practice placements. The Department commented that these figures excluded trainees currently receiving Band 3 payments, as continued employment in Band 3 was now a technical breach of the junior doctors' contract. The Department said it did not regard as an appropriate comparator hospital trainees on the highest banding who were undertaking high intensity work with duties at the most unsocial times, particularly in the absence of any formal data on the duties of GMP registrars, as was routinely collected for hospital trainees.

2.27 The Department commented that although a majority of hospital trainees were currently paid in Band 2, and that this was likely to remain the case over the next year, the pay of GMP registrars was already equivalent to that of an average hospital trainee (excluding Band 3 posts). The Department said that as it moved further towards compliance with the Working Time Regulations, GMP registrar posts at 65 per cent were likely to become increasingly more attractive in the longer term, as future hospital posts fell into Band 1 and attracted a maximum supplement of 50 per cent as a result of reducing hours. The Department noted that this would be true both in London and in other areas. The Department also said that it would be willing to consider with the profession, whether, in the interests of equity, future GMP registrar supplements should be based on the same banding criteria as those of hospital trainees.

2.28 With regard to the other issues drawn to our attention by the BMA, the Department reported that:

- pay protection for doctors taking up GMP registrar posts following service as a non-consultant career grade, or a post in public or military service, plus amendments to arrangements for sick pay and for payment of removal expenses, had been given effect from 1 April 2003;
- it recognised the disparity between the pay of a part-time GMP registrar and that of a part-time hospital trainee. However, the Department considered that the provisions of the hospital contract had effectively priced part-time trainees out of the workplace, caused resentment from full-time peers and strong opposition from NHS employers. The Department considered that the resolution of this problem rested in re-visiting the arrangements for flexible hospital trainees, but also ensuring that a resolution provided fair arrangements for GMP registrars; and
- it would be inviting the new NHS Employers' Organisation to take forward next year negotiations on the uplift to the motor vehicle allowance. The Department confirmed that the anomaly of different arrangements with regard to the excess rent allowance for married GMP registrars as opposed to single registrars had been removed with effect from 1 April 2003.

2.29 In supplementary written evidence, the BMA said that the Health Departments might be slightly optimistic in their assertion that the number of GMP registrars had been steadily increasing and expectation that those numbers would grow. It said that while the figures did show an increase, it felt the comparison given should be from September 1997 to September of each year and not June to ensure absolute accuracy and in order to take into account any in-year fluctuations. The vast majority of GMP registrars commenced their period of training in August and thus September was the best time to make a year-on-year comparison of figures. It also pointed out that the Departments had not taken into account the current vacancy rates as well as whole-time equivalent numbers, and had relied solely on head counts. It said that this would inevitably give a misleading figure. Furthermore, it said that it believed there were still considerable difficulties in recruiting GMPs to work in career posts in UK general practice after gaining their Joint

Committee on Postgraduate Training for General Practice certificates. Many now chose to work abroad or as locums. It said that many were also working part-time; thus, a figure of head count alone did not relate to the actual number of whole-time equivalent GMPs.

Comment

- 2.30 *We note here that the payscale of GMP registrars is aligned with the senior house officer (SHO) payscale. We make recommendations on the pay of SHOs in chapter 6.*
- 2.31 *In previous years, the Health Departments have made clear that they remained committed to the principle that the pay differential between GMP registrars and doctors and dentists in training in hospitals should not widen further, as they did not wish the pay arrangements for hospital doctors to have an adverse impact on the recruitment of GMP registrars. We ourselves have noted previously that there is an oddity in trying to retain the pay relativities between two groups whose workloads may be very different. However, we have accepted the Departments' policy and understand that recruitment is a key concern here. We also note that the latest available data on GMP registrars indicates that the number as at June 2003 was the highest ever recorded. We are also aware from the Health Departments' censuses that annual growth in the twelve months to September 2002 was five per cent. We have therefore considered our recommendation against this background of continuing growth in numbers.*
- 2.32 *In previous years, the Health Departments have made their own recommendation about the level of the GMP registrar supplement on the basis of the increase in average earnings of hospital juniors as a whole. This has previously included juniors working in Band 3, whereas this year the Department is arguing against the inclusion of Band 3 on the grounds that the employment of juniors in Band 3 is now a technical breach of the junior doctors' contract. We are also aware that from 1 August 2004, many Band 3 posts will be illegal under the Working Time Directive. The Health Departments' evidence on doctors and dentists in training makes clear that they are working hard to achieve compliance with the Directive from next August, and while we would consider it unlikely that all Band 3 posts will be eradicated from August 2004, it is clear that the Health Departments must strive towards compliance. We therefore agree that it would be inappropriate to base a decision about the GMP registrar pay supplement on Band 3 posts, as these posts should not even exist and we accept that employers will be striving to phase them out in 2004-05.*
- 2.33 *We agree that if Band 3 posts are excluded, the average supplement paid to hospital juniors in compliant posts is 66 per cent. Given the currently healthy recruitment position for GMP registrars, we see no need to increase the supplement from its current level of 65 per cent. We therefore **recommend** (recommendation 3) that the out-of-hours supplement for GMP registrars should remain at 65 per cent of basic salary during 2004-05. However, as we have said in previous reports, we would wish to review the level of the supplement in the next round, in the light of both further progress in reducing the hours of doctors and dentists in training in the hospital sector, and further evidence on the recruitment of GMP registrars.*
- 2.34 *We would also repeat the comment made in previous reports that as we would expect, at some future time, that there will be a need to consider reducing the supplement payable to GMP registrars, we would wish at that time to consider the position of those doctors who were then receiving the higher level of supplement. We still remain of the view that fairness suggests that such individuals should mark time, rather than see their pay supplement reduced.*

- 2.35 *We were pleased to note the parties' evidence that the pay anomalies affecting certain doctors taking up GMP registrar posts have now been resolved, as this has been outstanding for some while now. We were also pleased to note that there has been a resolution of the issues affecting excess rent allowances and sick leave arrangements for GMP registrars. We note that the BMA wishes to renegotiate the motor vehicle allowance and hope that as the Department of Health has handed the matter over to the new NHS Employers' Organisation to take forward, that this too can be expedited in time for the next round.*
- 2.36 *We note that the disparity between pay for doctors working less than full time in hospital and in GMP registrar jobs (flexible trainees) remains unresolved and that the Department of Health sees resolution of the problem resting in re-visiting the arrangements for flexible hospital trainees, and then ensuring that a resolution provides fair arrangements for GMP registrars. We must repeat our comments from previous rounds on this issue. We cannot comment on the original agreement to include flexible trainees in the new contractual arrangements for junior doctors and similarly, we cannot comment on what has been agreed between the parties in respect of flexible GMP registrars. However, the Health Departments need to consider carefully how they can ensure that their commitment to promoting flexible working arrangements, and the need to minimise retention difficulties, are supported by the flexible trainee scheme, both in the hospital sector and in general practice. Like the flexible trainee scheme for hospital doctors, the arrangements for flexible GMP registrars will be an increasingly important part of any retention strategy for the primary care sector, given the demography of the medical school intake.*

GMP educators and trainers

- 2.37 The **BMA** drew our attention to the significant progress it said had been made in negotiations with the Health Departments in drawing up salary scales for GMP educators. It also reported that it had sent a survey to a sample of 500 current GMP trainers. A total of 281 completed surveys were returned (56 per cent response rate) with a majority of respondents stating their workload had increased. The BMA said that this would continue as trainers would be needed to undertake various roles in appraisal, assessment, support of under performing doctors and revalidation. The survey had also revealed the time required for informal teaching and training-related administration, which the BMA said was difficult for trainers to justify to their GMP partners, given the current remuneration. The survey had shown that 92.3 per cent of respondents felt that the current level of grant did not adequately reward their work as a trainer. Factors thought important for recruitment and retention were increasing the grant (48.7 per cent support), and support with expenses and infrastructure costs. The BMA considered that training the next generation of GMPs was vital, and it suggested that a substantial increase in the trainers' grant would encourage GMPs to become involved in training, either for the first time or by returning to it.
- 2.38 In supplementary evidence, the **Department of Health** said it acknowledged the important role of all GMP educationalists, including GMP trainers, and said it had already undertaken work with the BMA to look at the remuneration for the tier of educationalists above the trainers. The Department said that it was now taking forward the *Modernising Medical Careers* initiative, which may potentially change the structure of training for general practice, the types of experience needed, and the numbers of doctors in training spending some time in general practice. In doing so, the Department said it would be necessary to consider the range of supporting arrangements, including a system of rewards for those delivering training.

- 2.39 In supplementary written evidence, the **BMA** said that it did not believe that *Modernising Medical Careers* would lead to a satisfactory resolution to the problems of remuneration for GMP trainers. In addition, it said that trainers' pay was negotiated separately from educationalists' pay. It said, therefore, it was inappropriate to try and merge the two and to suggest that trainers' pay was currently being dealt with.

Comment

- 2.40 *Firstly, we welcome the BMA's evidence that significant progress has been made in negotiations with the Health Departments in drawing up salary scales for GMP educators.*
- 2.41 *When we were last asked to look at the issue of the GMP trainers' grant for our Thirty-First report, we commented that we had been presented with only part of the case for considering whether the grant required adjustment. As well as understanding the time commitment involved in this work (and how this might have changed in recent years), there was also a need to explore the loss of income resulting from GMPs acting as trainers. We asked the parties to discuss this further and to prepare joint evidence for our consideration in the next round, if it appeared that a case for adjustment was warranted. In exploring any loss of income incurred by a GMP trainer in undertaking this work, we would also ask the parties to take into account the fact that a GMP registrar is an additional resource for the practice whose work may generate revenue to offset at least some part of any income loss by the GMP principal.*
- 2.42 *Since our Thirty-First Report, a review of the structure of training for junior doctors has been carried out and the Department is now arguing that the system of rewards for those delivering training should be considered alongside the implementation of changes from *Modernising Medical Careers*, which may potentially change how training for general practice is conducted. We consider this to be a reasonable approach, but would urge the Department of Health not to delay unduly its consideration of the remuneration of GMP trainers. We see the recruitment and retention of these individuals to be of continuing importance, given the importance of the Government's primary care agenda. We therefore ask the parties to report on progress for our next review. For this round, we **recommend** (recommendation 4) that the level of the GMP trainers' grant is uplifted by 3.225 per cent for 2004-05.*

GMP clinical assistants working in community hospitals

- 2.43 The **BMA** asked us to note that the responsibility for this group of doctors had passed to the General Practitioners Committee (GPC) in October 2003. The BMA invited us, as a matter of urgency, to:
- review the current pay system, which it said was chaotic and unfair; and
 - undertake a workload survey.
- 2.44 The BMA said that GMPs working in community hospitals were often paid at a rate not commensurate with their experience and skills. Many did this work in their own time, which in turn was often covered by their practice partners, and this was becoming increasingly untenable, both financially and given current workforce shortages. The BMA commented that GMPs working in community hospitals had a high level of clinical responsibility, but the current level of pay took no account of the time required to maintain these specialist skills, or of the level of clinical leadership and administrative management required of these doctors.

- 2.45 Various other relevant factors were discussed, including the demands of rural areas, the need for site attendance, and the role of community hospitals as a “safety valve” for district general hospitals, which meant GMPs often acted in both house officer and consultant roles, but without the clinical support services of a district general hospital. The BMA said that the changed role of these hospitals meant that GMPs were handling a broader range of cases. There were currently approximately 400 community hospitals and approximately 4000 GMPs working in such hospitals, but these doctors had never been accurately rewarded. The BMA said there was now a real possibility that some practices would withdraw from this work as a consequence of the greater rewards under the GMS contract.
- 2.46 In supplementary written evidence, the BMA said that many GMPs work in the almost 400 community hospitals. Most who undertook this work were, at present, involved in GMS out-of-hours provision for their own practices and had been simultaneously supporting the community hospital out-of-hours cover alongside their GMS service. Much of the out-of-hours cover for community hospitals was demanding, with GMPs working as frequently as one night in two. Under the new GMS contract, GMPs would have the option to opt out of providing out-of-hours GMS altogether. It said that given the haphazard contractual and funding arrangements for community hospitals, it strongly believed that a great many GMPs undertaking the work would simply give notice to opt out of community hospital work by the end of 2004, with disastrous consequences for community hospitals.
- 2.47 The BMA said that GMP recruitment and retention, particularly in rural areas, had been affected in the past by new GMPs not wanting to undertake such onerous work. There would be serious ramifications for rural or isolated practices if action was not taken to deal with the issue now. It said that the GPC was aware of practices wanting to renegotiate their contracts with their local community hospital trust and there were already GMP practices in Wales that had given notice of withdrawal of services in three months, while some in Derbyshire had withdrawn already. It said that such withdrawals would affect not only the night cover, but also services provided during the day. This could result in the widespread loss of GMP cover, and potentially the consequential loss of thousands of beds from use in the NHS, many of which were used to maintain district general hospital bed-state flexibility. It said it could be months before an alternative, and undoubtedly more expensive, medical service was in place to “re-activate” the beds, but the knock-on effect on patients and the pressures on the NHS would be severe unless urgent steps were taken to incentivise continued GMP community hospital work.

GMP clinical assistants and hospital practitioners not working in community hospitals

- 2.48 As for the previous group of doctors, the **BMA** asked us to note that responsibility for this group had also passed to the GPC in October 2003. The BMA said that many GMPs undertook this work in their own time, covered by their practice partners, and so were not receiving payment for locum cover. Workforce shortages meant this was becoming increasingly untenable. The comparison of the sessional rate of pay with staff grade doctors, which had been made by PricewaterhouseCoopers, was not entirely appropriate and the BMA suggested that a more relevant comparator would be the cost of replacement – for example, salaried GMPs employed under PMS contracts were earning between £55,000 and £60,000 per year. Pay also needed to take account of the time required for continuous professional development. The BMA recommended a significant pay uplift for these GMPs, in line with hospital consultants, to recognise that job weight and hours worked were not properly rewarded at present.

2.49 In supplementary evidence, the **Department of Health** said that in its evidence for our Thirty-Second report, it had indicated that it would take forward reforms of the clinical assistant and hospital practitioner grades in the wake of the GMS contract reforms. Now that the GMS contract had been agreed, the Department said it was keen to press ahead with this and it was intending to do so alongside the review of pay arrangements for the staff and associate specialist grades. The Department said it wished to move towards a system that better recognised the competence of individual doctors in the staff, associate specialist and related grades. It said that, as the BMA had suggested, many clinical assistants and hospital practitioners had a wide range of knowledge, skills and expertise that would be more appropriately recognised once a clear competency framework was in place. The Department said this would also facilitate doctors wishing to make a career change from GMP to hospital practice in future.

Comment

- 2.50 *It is unfortunate that there has been no progress in considering the issues affecting both of these groups, but we accept that the negotiation and implementation of the new GMS contract has been a priority for all the parties. However, we hope that the Department of Health will now make good progress in looking at these two groups as part of its wider review of the staff and associate specialists/non-consultant career grades. We would expect to receive evidence to this effect for the next round.*
- 2.51 *We have said in our two previous reports that a fundamental review of clinical assistants and hospital practitioners working in acute trusts was needed and that consideration of changes to the current pay structure should follow on from a review. This remains our view and we do urge the Department of Health to take this work forward speedily. We would remind the parties that the use of clinical assistants and hospital practitioners also requires the Health Departments to make a judgement about relative priorities for the resources deployed in primary and secondary care. Any significant decisions about pay should be taken in the light of the policy decision about the need to divert primary care resources to support secondary care services.*
- 2.52 *We have commented in previous reports on the need for a survey into the quantum and complexity of the work performed by GMPs working as clinical assistants in community hospitals and that until such a survey is completed, we have no basis on which to make recommendations. The Department of Health confirmed to us in oral evidence that GMPs working as clinical assistants in community hospitals would be considered, alongside other clinical assistants, as part of its wider review of the staff and associate specialist/non-consultant career grades. We therefore expect the Department to take forward consideration of the issues affecting GMPs working in community hospitals, including pay issues, and we expect to receive reports of good progress for our next review.*
- 2.53 *We are aware of the BMA's concern about the possible widespread withdrawal of GMPs from community hospital work once the new GMS contract is implemented later this year. Community hospitals perform a vital service for many isolated or rural communities and we would be very concerned at the impact on the public if any trend started to develop of GMPs withdrawing their services. We would therefore **recommend** (recommendation 5) that the Department of Health view this particular group as a priority in taking forward its review of clinical assistants and hospital practitioners. Once again, we would expect to hear reports of good progress for our next review.*

Personal Medical Services

- 2.54 The **BMA** observed that a recent letter from the Minister of State for Health in England to PMS GMPs had made clear that PMS was now a permanent alternative to GMS. The BMA said it had been concerned to learn firstly, that in PMS, there would be provision to develop local variations of the quality framework, secondly, that the overall money available for the quality framework in PMS would be lower than in GMS, and thirdly, that for the same or similar outcomes, GMS practices would have clearly defined payment criteria, whereas payments to PMS practices would be locally determined. The BMA said that this potential inequity between GMS and PMS needed to be recognised at a national level, and that levels and methods of payment should be carefully monitored.
- 2.55 In supplementary evidence, the **Department of Health** said that PCTs and practices would have the ability to develop local variations of the GMS quality framework, which may better reflect local circumstances, or build on quality arrangements already in place. The Department said that PMS practices would be required to demonstrate to the PCT or the SHA that local variations would deliver broadly comparable levels of evidence-based quality improvements for their patients. However, the Department said beyond that, the arrangements would be a matter purely for local determination.

Comment

- 2.56 *We note the evidence from the parties on the implementation of the quality framework under PMS. Although the quality framework itself lies outside our remit, we would hope that its implementation across general practice has no adverse impact on the morale of GMPs, whether they are working within GMS or PMS. We would also expect the operation of the quality framework to deliver remuneration equitably to GMPs who are meeting the same standards, whether they are working in GMS or PMS, even if this remuneration is delivered to GMPs in different ways. We would ask the parties for further evidence on this for the next round.*

Sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities

- 2.57 The **BMA** explained the background to and purpose of the 'collaborative arrangements', telling us that the low level of fees for reports by GMPs and others in adoption and fostering processes were seriously discouraging medical participation. The BMA also said that the low level of sessional payment for work in the community health service, as compared to other medical work, was making it increasingly difficult for the agencies involved to secure doctors' services.
- 2.58 The BMA commented that fees for this work had for many years lagged behind those for other similar work, partly because of the Health Departments' unilateral decision a few years ago to allow local negotiation of fees, and partly because the work was done by so many different groups of doctors, none of which had 'ownership'. The BMA reminded us that it had agreed with the Health Departments a few years ago to hold an enquiry to establish how much was paid under these headings and the different mechanisms for payment. The BMA said that unfortunately, this enquiry was never set up, partly due to continuing NHS reorganisation, and partly because of the various contract negotiations. In the absence of such information, the BMA asked us to recommend that these fees should in future be based on the BMA's 'Treasury' rate for work for central Government departments and agencies – currently £123.50 per hour for consultants and £107.50 per hour for GMPs.

- 2.59 In supplementary evidence, the **Department of Health** said that it felt strongly that payments under these arrangements should be kept in line with NHS earnings. It said that for GMPs, it had agreed that, in future, all NHS earnings – including earnings from collaborative fees – should be pensionable within the NHS Scheme. It asked us to take account of the fact that this had sharply increased the value of the work done under the collaborative arrangements. The Department said it did not believe that any further increase to the value of the fees was justified.
- 2.60 In supplementary evidence, the **BMA** said that one consequence of the new GMS contract was that practice expenses were now only reimbursed for the specific services for which a practice contracted, rather than being reimbursed across all the practice's activities. This meant that the expenses for any work a practice undertook which were not funded within the various new contract funding streams must be funded via the fee that the work attracted. If GMPs were to be encouraged to continue to do important work such as the collaborative arrangements, it said the fees must be increased to compensate the practice for its expenses in undertaking the work. It said that the recent European Court of Justice judgment in the *d'Ambrumenil*² case might also require larger practices to levy value-added tax on certain fees for work under collaborative arrangements. It said there was already evidence that some practices were increasingly reluctant to take on loss-making work under the collaborative arrangements: the British Agencies for Adoption and Fostering had reported instances of practices refusing to provide medical reports for adoption and fostering.

Comment

- 2.61 *This issue has been raised for our consideration, but we have received no evidence on which to make a recommendation. The work for which these fees relate covers a range of Departmental interests and it seems right for each individual Department or Agency to review the matter with the BMA. Until such time as this is done, we only intend to recommend a general uplift. We therefore **recommend** (recommendation 6) that these fees are increased by 3.225 per cent for 2004-05. We would ask the parties to report to us for our next review on what progress is being made to review these fees.*

² The BMA said the reference for this case was Court of Justice of the European Communities – Published November 27, 2003 – *d'Ambrumenil and Another v Commissioners of Customs and Excise* Case C-307/01 – Judgement November 30, 2003.

CHAPTER 3: GENERAL DENTAL PRACTITIONERS

- 3.1 *Consideration of the parties' evidence this year was set against the background of the forthcoming change to the arrangements for NHS dentistry in England, when from April 2005, local commissioning and funding of dental services through Primary Care Trusts (PCTs) will be introduced. The year to which our recommendations apply (2004-05) will therefore be a transitional year in England before the new arrangements come into effect. In making our recommendations for this round, we have focused on the need to facilitate the move to this new regime.*
- 3.2 *The parties' evidence was also set against the background of this forthcoming change and a number of issues were raised for our consideration, including the "lag effect" and dental expense inflation, seniority and commitment payments, capital support and return on capital, and the introduction of a practice cost allowance. We consider the various issues below, after the summaries of the parties' evidence.*

Legislation and preparation for implementation

- 3.3 The **Department of Health** told us that the Health and Social Care (Community Health and Standards) Bill had completed its first Commons stage in the summer, and Committee Stage in the House of Lords in October. Subject to Parliament, it was intended to implement the dentistry aspects of the legislation from April 2005 which would:
- give PCTs new duties to secure dental services and direct control over the funding of dental services;
 - give greater financial stability for practices through contracts for services;
 - enable PCTs to provide assistance and support to dental practices with whom they contracted;
 - abolish the Dental Practice Board and replace it with a special health authority; and
 - introduce a new system for patient charges.
- 3.4 It said that it had drawn up plans to manage the transition to local commissioning of NHS dentistry which flowed from the Bill.
- 3.5 The Department said that the Bill also provided for a transitional scheme for dentists, entitlement to a contract for those dentists who were providing General Dental Services (GDS) under the current arrangements, and protection of legitimate earnings. It said that the setting up of new arrangements within the NHS had been balanced by an extensive programme of work with the British Dental Association (BDA) to develop an agreed transitional scheme. The work was currently focused on agreeing the contractual arrangements for dentists during the transitional period, with the key imperative to provide certainty for the majority of dentists in the run-up to and through the transition to local commissioning. It said this was the simple but robust 'base contract' which for most general dental practitioners (GDPs) was likely to form the transitional scheme provided for in the Bill. In supplementary evidence, the Department said that the Health and Social Care (Community Health and Standards) Act 2003 had received Royal Assent on 20 November 2003.

- 3.6 The Department said it recognised that the scale of change facing dentistry raised a great deal of uncertainty and concern for dentists, including questions about entitlement to contracts and protection of earnings. The Minister of State and the Chair of the BDA's Executive Board had therefore jointly written to all GDPs in England to make clear that for dentists working in salaried primary dental care, in the Community Dental Services, Personal Dental Services (PDS) or salaried general dental services, existing employment contractual arrangements would continue; and for all dentists providing GDS, when local contracting began, they would be entitled either to the new base contract, or a variant of it agreed with the practice. The base contract would guarantee practices broadly the same level of current gross income (or turnover) for broadly comparable levels of work (increased by any agreed uplift for 2005-06 following our recommendations). The Department said the aim was to protect practices and to minimise bureaucracy whilst improving access and quality of service for patients. It said it would be working with the NHS to ensure that practices contracting with PCTs did not lose out financially. The Department said that crucially, dentists would come off the much criticised treadmill of item of service from day one of the new arrangements.
- 3.7 The Department said that budgets for individual practices would be based on the most recent agreed period for which information was available. It would be possible for budgets to be uplifted to take account of changed circumstances where they were agreed: for example, periods of maternity leave or the planned arrival of a new partner. Under the new system, practices would be paid their practice price in 12 equal monthly instalments. In return, practices would have to provide minimum information for clinical and activity monitoring purposes, and to access and verify patient charge revenue. It said the new contract would create a more flexible, professional environment and GDPs would be able to practise as they were trained to, focusing on quality and individual patient needs, rather than being driven by the item-of-service regime. The Department said that the initial gross practice earnings guarantee, together with the fact that the contracts were likely to be on a three-year rolling basis, should also give security to practices and a better income guarantee for practice development purposes than in the past. The expectation was that the base contract would cover dentists providing the generality of dental services, with more specialist services, such as orthodontics or sedation, likely to require arrangements similar to PDS. In addition, the Department said that it proposed that out-of-hours responsibilities should lie in future with PCTs rather than with individual dentists or practices. In supplementary evidence, the Department said that practice funding would not be reduced as a result and that those dentists who wished to could contract for out-of-hours work separately.
- 3.8 The Department described some work that had been carried out in field sites to test the concepts set out in *Options for Change*. This work, together with work on the base contract and earlier work on PDS pilots, gave three tiers of 'contracting' work relevant to the taking forward of new ways of remunerating dentists: PDS under existing legislation; field sites, also under existing legislation, essentially using PDS flexibilities; and the base contract for the transitional scheme under the new legislation. It said that a common theme across the three tiers was the management of risk to and growth of dentists' NHS income. Ministers had made clear in both Houses that it was intended to grow the investment in NHS dentistry over time. The Department said this needed to be managed in a way which provided safeguards both to dentists and the NHS.
- 3.9 The Department said that the Bill represented the most radical reform of NHS dentistry since 1948. It said that it was possible to introduce some reform in advance of the legislation to modernise NHS dental services, and from September, the effectiveness of dental prescribing had been improved with the inclusion, at the BDA's request, of several new drugs and medicines. It said it would be possible to extend the range further, subject to the passage of the Bill.

- 3.10 The **National Assembly for Wales** said that it was collating and analysing the responses to the Wales Dental Workforce Review Report. It said that the Health and Social Care Bill currently making its way through the UK Parliament would bring about primary legislative changes that would be applicable to Wales, and would enable the reform of dental services in Wales.
- 3.11 The **BDA** said it had been working towards a smooth transition from the current system of remuneration and delivery of NHS dentistry to the new system beginning on 1 April 2005, as the implementation of the Health and Social Care Bill (England) came into effect. The BDA said that the Bill basically devolved the commissioning of dental services and funding to PCTs in England.
- 3.12 It also said it had been working in conjunction with the shadow special health authority/Department of Health on agreeing the details of the base contract for practitioners needed to implement the new commissioning arrangements. The BDA said that to date, some progress had been made on determining the broad content of the contract. It was also representing the profession on the Department of Health's Dental NHS Patient Charges Working Group with the aim of devising a new patient charges regime that was less complex and more understandable to both patients and practitioners. The BDA said that the other concerns of the profession which it was working to address included issues relating to superannuation, the IT strategy, and the role of stakeholders with local commissioning.
- 3.13 The BDA commented that access to NHS dentistry remained a very serious problem for patients. GPs were becoming more and more frustrated with the present system that applied increasing pressure to them to compromise their role as health care professionals. The BDA said it was accepted that the implementation of the Health and Social Care Bill (for England) in 2005 had the potential to address some of the anomalies contained within the present system of remuneration. However, the BDA said that the continued failure to retain practitioners within the NHS, the difficulties associated with accessing much needed capital support, low returns on capital expenditure and continued dental practice inflation all remained key concerns to practitioners.

Comment

- 3.14 *We said in our last report, in the wake of the BDA's rejection of the Department of Health's offer of a three-year pay deal for GPs, that we were concerned that there should be no ill feeling between the two sides, and that the parties should continue to work constructively together to move the agenda for the GDS forward. We also said that we viewed the introduction into Parliament of the Health and Social Care (Community Health and Standards) Bill in March 2003 as a very important development that demonstrated to us that the reform process was moving forward. We therefore welcome the successful passage of the Health and Social Care (Community Health and Standards) Act 2003 last November, and the constructive spirit in which the parties appear to be taking forward work to implement the new local commissioning regime in April 2005.*
- 3.15 *In our last report we accepted that reform of the current system for general dental services must be the way forward in the medium term, and that is still our view. We also recognise, as does the Department of Health, that the forthcoming changes in NHS dentistry will have raised uncertainty and concern amongst dentists, and that there will be particular concern about entitlement to contracts and protection of earnings. We therefore welcome the Department's assurances that the work under way on the transitional scheme is intended to deliver assurances in both areas. We would ask the parties to report on their progress in agreeing the details of this scheme for our next review. We hope that work on implementing the new arrangements can progress smoothly and that practitioners can be kept fully informed by both the Department and the BDA of the progress being made, and how this will impact on them.*

Investment

- 3.16 The **Department of Health** said that Ministers had given a commitment that the net GDS budget (now approaching £1.3 billion) would be devolved to PCTs from April 2005, and that the budget would be “floored” (in other words, PCTs could spend more but not less) and that it intended to grow the investment in dentistry over time. It said that by setting a floor on the spending for primary dental services below which the PCT could not fall, the financial resources allocated for dental services would be used for the purpose for which they were intended.
- 3.17 The Department said that it had made available £59 million to support the three-year pay deal. Despite the BDA’s rejection of the deal, it said it had given a commitment to invest the GDS share of the funds in NHS dentistry through PCTs. The Department said that it was honouring that commitment, and had in fact decided to invest over £96 million over the three-year period. It said that £35 million (capital funding) was to be allocated through PCTs to address local problems on access, choice and quality. It said that the three-year pay deal included a further £9 million for dental access and those funds (£3 million this year and £6 million next) would now be used to back the NHS Support Team, which had been set up to support the hardest pressed PCTs and practices to improve access. On top of that, in response to a request from the BDA, £1 million was being made available over the next two years to support organisational development between PCTs, local dental committees and dentists for the new world of commissioning. The funds were intended to enable training to be purchased, or local seminars to be organised. Additionally, the Department said it was investing £30 million over three years in dental information technology (IT). It said that in future, the development of IT for NHS dentistry would move in parallel with that for general practice and hospitals and would be part of PCTs’ local IT plans. This, combined with the fact that practices could still claim a grant of £900 when they started submitting data electronically to the Dental Practice Board/special health authority, should encourage the use of IT and a reduction in the administrative burden on practices. The grant would be made available in advance of electronic submission in return for a commitment to submit data electronically within six months of grant payment.
- 3.18 The Department said that it had announced that in relation to its future duty to commission dental services, there should be a dentist on all PCT Executive Committees to meet the requirement that its professional members reflected the functions carried out by the Trust. New funding of £200,000 had been announced to support leadership training for dentists at local level to take such roles. Additionally, the Modernisation Agency would appoint a national coordinator for skills development in NHS dentistry at PCT level. Finally, the Department said that it planned to spend £16 million over three years for local dental workforce recruitment and retention. This would include the appointment of a dental recruitment and retention leader in all local Workforce Development Confederation areas. It anticipated that £1 million would be spent nationally on international recruitment.

Comment

- 3.19 *We note the funding that the Department of Health is making available over the next three years to support NHS dentistry, and that this will be targeted locally through PCTs, rather than generally across the GDP population as a whole. We said in our last report that we welcomed the Department’s confirmation that the £59 million of funding which was to have been made available to support the three-year pay offer for GDPs would still be available to support the GDS (less whatever was to be set aside for the salaried services). We note that the Department has confirmed that this money forms part of its current funding plans. In the*

last round, the BDA confirmed that it would be working with PCTs to ensure that maximum benefit of the funding was given to the GDS, and we hoped that the parties would work effectively together to target money where it could be used most effectively. This is still our hope and expectation and we would ask the parties to report on progress in the next round. We are particularly interested to know how widely the funding is being deployed.

Recruitment, retention and morale

- 3.20 The **Department of Health** said it had introduced changes previously agreed with the profession, to increase the period of maternity pay from 13 to 26 weeks, to introduce two weeks' paternity pay, and to introduce pay for adoptive leave. It said that it estimated that the changes would generate some £3.6 million in additional costs for the GDS.
- 3.21 The Department said there were now more dentists in the GDS in Great Britain than ever before, with 21,455 dentists as at 31 March 2003, 99 more than the year before. However, it said that a number of dentists were reducing their NHS commitment, as a result of the "treadmill" of the current contract, the bureaucracy associated with operating it and the relative ease with which dentists could switch from NHS to private work. The Department said that it was not the overall level of remuneration which was the problem, but what dentists had to do to earn the money. It said that this would all change with the abolition of the national contract and item of service in April 2005. In advance of that, for practices that did not wish to wait until 2005, the Department said that it had encouraged PCTs to offer practices the option of switching to a PDS contract in the current year, to solve the treadmill problem. A commitment had been given to process such PDS applications very rapidly and provide model contracts from existing PDS sites to minimise the workload of the switch for practices. Post-2005, PCTs would have the ability to provide any assistance they judged necessary from their general NHS allocations to support dental practices. In advance of that, to help PCTs address practices under most pressure, the Department said it had made directions giving PCTs equivalent powers under current legislation.
- 3.22 The Department noted that in our last report, we had again requested evidence on the size of the workforce needed to produce the level of dental care it felt appropriate. The workforce review had established a number of features of both the supply and demand and broadly concluded that changes in the supply side make-up meant that some additional growth in workforce numbers was likely to be needed. In the shorter term, it said it would look to recruit more dentists from overseas and provide additional support for foreign dentists to become eligible and competent to work in the NHS. It said it was also increasing the number of training places for professions complementary to dentistry, including 150 extra places for dental therapists over the next two years. In terms of demand, it said demography and improved general health had already led to a major restructuring for dentistry, and a much smaller proportion of the population now required the majority of the active treatment needed. At the same time, it said there was a continuing health maintenance need for a large part of the population and, to come, a likely increasing need for maintenance of restored dentition from people who had received considerable treatment in the past and who would live longer and generally healthier lives than earlier generations.
- 3.23 The Department said that managing changing demands was a legitimate requirement for the NHS, but there were few precedents for estimating and responding to changing healthcare demand of that kind. It said that the model for a different approach to service provision was in *Options for Change* and that the components of the delivery system were being built up by iterative work with the profession and the service.

Important for the future would be the greater involvement of professionals complementary to dentistry. One of the components needed for delivery was a clear model for recalling patients for inspection, according to the risk of the need for treatment. It said that other areas of primary health did not generally recall low risk patients routinely. It said that the separation of clinical activity from remuneration on a continuing care/item-of-service basis would aid the approach, as the existing recall pattern was largely driven by that. It said that the National Institute for Clinical Excellence was expected to provide advice on this, but for the time being, it was not possible to be clearer about the precise relationship between the workforce and the level of dental care needed by the NHS.

- 3.24 The Department said that at the same time, there was a very significant complicating factor introduced by the development of a thriving market for private dentistry. The private market offered dentistry of more kinds with a great diversity of choices available for those patients who could afford to pay. It said that, as with other areas at the boundaries of clinical healthcare and services promoting well-being, the growth of more diverse markets was a well-established part of modern life. A recent report by the Office of Fair Trading¹ noted that the market for private dentistry had doubled in size in the last five years and estimated its worth at about £1 billion. A private dentistry report by Laing & Buisson² described private dentistry as the most rapidly expanding part of the healthcare sector.
- 3.25 The Department said that the dentists engaged in the expanded market for private dentistry were for the most part previously engaged in providing dentistry for the NHS, and to the extent that the workforce had expanded in terms of headcount, it was providing proportionally less NHS treatment per dentist. Essentially, it said there was no longer a monopoly position, but a range of purchasers competing for the services provided by dentists. The NHS was merely one of those purchasers, albeit the largest. It said that the NHS' failure to compete effectively for the services of the workforce and to respond to the growth of the private market lay behind the problems of maintaining NHS dentistry over recent years. The Department said this underlay the strong Government commitment to reform and restructure the relationship between the NHS and the dentistry workforce. However, it said that the NHS could not be drawn into a bidding war with the private market over pay rates. Its aim was to develop a progressive service where dentists could fully develop their skills to deliver wide-ranging and effective clinical care, with the opportunity for integration into the NHS professional and wider care networks, whilst enjoying the broader support and security in working conditions which a large scale and holistic health system such as the NHS could provide.
- 3.26 The Department said that the workforce was responding to a market described as 'the most rapidly expanding sector in healthcare' and was presumably increasing its total remuneration at a commensurate rate. Simply increasing NHS remuneration was neither possible nor appropriate. The Department said that it meant a change in NHS-workforce relations of a different order from those currently underway in other parts of the NHS workforce. From one perspective, it said that a slightly enlarged workforce (over the last five years) had increased its income by about £500 million. It considered that this perspective, of the NHS competing rather poorly in a market for the services of dentists who were increasingly operating in a plural way, threw some light on the evidence provided by the BDA on morale. The Department said that it was well aware of the

¹ *The private dentistry market in the UK*, Office of Fair Trading, March 2003

² *UK Dental Care – Market Sector Report 2003*, Laing & Buisson, January 2003

need to provide better working conditions and more satisfactory remuneration arrangements for dentists who were committed to the NHS. However, it said that given the growth in private income, the question of morale needed to be viewed with some caution against the background that dentists in most parts of the country appeared to be sharing in the growth in the private market.

3.27 In conclusion, the Department repeated that the Government remained committed to NHS dentistry and had taken steps to ensure that the item-of-service fee arrangement – the much reviled treadmill – would go as part of the move to local commissioning, thus delivering from day one of the new arrangements the change which the profession had been urging most keenly.

3.28 The **National Assembly for Wales** said that there were problems of access to NHS dentistry in several parts of Wales, particularly the rural areas. It said that to improve access to dental care, an additional £833,000 over two years had been allocated for the purchase of access sessions from dentists. It said that stage three of the Welsh Dental Initiative included grants linked to vocational training in order to attract young graduates to rural areas and for practices to achieve the training standard.

3.29 The **Scottish Executive Health Department (SEHD)** said that it had introduced a number of initiatives to improve access to dentistry and to improve recruitment and retention of dentists in the NHS. It said it was too early to evaluate the impact of the initiatives, but there were encouraging signs of change, for example, all vocational training places available in designated areas were filled quickly, possibly as a result of the special £3,000 allowance introduced in August 2002. It said a number of enhancements had been made to the existing package of initiatives. An interim payment of £2,000 was made to all vocational trainers while a review of the level of a more permanent grant was ongoing. From August 2003, vocational trainers received a grant of £926 a month (£11,112 per annum). In addition, vocational training practices received an additional practice allowance of £1,500. Continuing Professional Development Allowance rates had risen: the standard rate was £97.57 for education sessions of 1 – 2 hours and £195.13 for education sessions of 2 – 3.5 hours. Remote areas' dentists could claim an additional £97.57 or £195.13 for the same periods. Senior dentists could earn a potential £13,100 through seniority payments. It said that there had been 48 Scottish Dental Access Initiative grants made since 1997, totalling nearly £1.4 million, for the establishment or expansion of NHS dental practices in areas of high oral health need. A guidance leaflet for dentists which advised on grants and allowances on offer had been distributed to all established practitioners, dental undergraduates and vocational trainees.

3.30 The SEHD described a number of pledges it had made on dental services:

- to invest in health promotion and, as a priority, to introduce free dental checks for all before 2007;
- to pursue further the mechanisms that encouraged preventive dentistry and design appropriate reward measures to support them;
- it recognised the need for an increase in the number of dentists and dental graduates in Scotland, and in response would undertake an assessment of the reasons for the shortfall in the number of dentists in some areas and the options for addressing that; and
- to expand the capacity of dental training facilities in Scotland by establishing an outreach training centre in Aberdeen, and consult further on the need for its development to a full dental school.

- 3.31 It said that work towards the implementation of the pledges was underway.
- 3.32 The **BDA** said that the issue of retention of dentists within the GDS was well recognised, as many practitioners had been moving away from undertaking NHS work and into private work. It referred to the OME's Survey of GPs' Workloads³ in 2000, from which it suggested that between 2000 and 2005, the equivalent to around 1,000 full-time wholly committed GDS dentists were to be lost from the GDS each year.
- 3.33 The BDA also said that its 2002 Dental Business Trends Survey had shown a sharp rise in the proportion of practice owners experiencing difficulty in the recruitment of associates: 44 per cent of practice owners defined as less committed to NHS work (i.e. less than 75 per cent of the practice's income was derived from the NHS) reported such recruitment as "hard"; and for those practice owners with a high NHS commitment (i.e. 75 per cent or more of the practice's income was NHS derived), 66 per cent said recruitment was "hard". The BDA said that the failure to retain GDS dentists was now manifesting itself in practice closures and vacant surgeries around the country. It said that it had been able to identify at least 40 NHS dental practices that had closed down due to an inability to be sold on, and over 200 vacant surgeries or "dental chairs" (in England and Wales) that remained unfilled due to a failure to retain and recruit associates willing to take on an NHS list. Based on data from a sample of areas that contained around one third of the population of England and Wales, it said that it was likely that there were over 550 vacant surgeries in England and Wales. In the British Dental Journal of October 2003, the BDA said there were 254 dental practices across the country attempting to fill practitioners' positions. It said that the situation of vacant surgeries also adversely affected their practice owners as the empty surgery became a financial loss to the practice, with fixed or sunk practice expenses continuing to be paid. It said that this financial liability acted to further drive committed NHS practitioners, particularly practice owners, out of the NHS. The BDA said that the loss of practices providing NHS care could not be in the public interest at a time when access to NHS dentistry was such a problem.
- 3.34 The BDA said that Denplan, Practice Plan and DPAS were all organisations that assisted in the conversion of dental practices to independent status (i.e. private conversions). It said that in the year to 2003, around 200 dental practices had converted to private practice and that by the end of the year, the figure would exceed 260, or 2.4 per cent of the total number of dental practices in the UK. The BDA said that it considered this a significant reduction in NHS service provision, especially given the results from the 2001 BDA Omnibus Survey which indicated that around seven per cent of practice owners already considered themselves to be largely private practices. It also said that it reinforced the findings it presented in the BDA Research Bulletin of January 2002, which indicated that 17 per cent of practices were currently in the process or were planning to move towards being largely private. It said that more practices in the south of England were seeking to become largely private, and that sentiment was constant across differing age groups. It said that research suggested a conversion rate of 300 practices per annum, a rate it said was confirmed from the Denplan, Practice Plan and DPAS evidence.

³ *Survey of General Dental Practitioners' Workload*, BMRB Social Research, 2000

- 3.35 The BDA said that this evidence strongly refuted the statements made by the Department of Health two years ago, when they stated that "...they did not recognise any major haemorrhaging in the workforce"; or last year when "...the Department therefore considered that the drift out of NHS dentistry was around one to two per cent a year". The BDA said that access to NHS patient care was being compromised as dental practices moved out of the NHS. It said that with the implementation of the Health Bill in England only 18 months away, it was imperative that the NHS retained an adequate workforce to deliver the vision of a modernised NHS dental service. Continuation of the current rates of conversion could mean that the workforce and the practices required by the NHS in 2005 simply might not exist.
- 3.36 In supplementary evidence, the **Department of Health** said that practices needed to change to reflect shifts in the population. The Department also said that the total number of dental practices had been increasing. There were 9,164 surgery addresses in August 1997 in England and Wales, with 9,350 surgery addresses in August 2002.
- 3.37 The **General Dental Practitioners' Association** (GDPA) said that although the number of NHS dentists had increased year on year, the actual spend on dentistry had not changed significantly, and output had decreased. It also said that recruiting dentists from developing countries was inequitable.
- 3.38 In supplementary written evidence, the **Department of Health** said that international recruitment was primarily from those member states of the European Union which had a surplus of qualified dentists. It said that some recruitment was also likely from India where it had an agreement with the Indian Government to safeguard their health services.

Comment

- 3.39 *We note the Department of Health's evidence that there are now more dentists in the GDS in Great Britain than ever before, based on headcount data as at 31 March 2003, compared to the previous figure for the year ended 31 March. We do note here that looking at time series data for the year ended 30 September that the numbers in the GDS in Great Britain had previously been higher, at 30 September 2001 and 2002. However, the numbers as at 31 March 2003 represent an increase of just 0.5 per cent over the preceding twelve months. We would also make the point here that headcount figures in isolation do not give an accurate picture; we also need to know the whole-time equivalent figures for dentists in the GDS.*
- 3.40 *We have said in our last two reports that we would welcome greater clarity about the resources needed for NHS dentistry as a basis for assessing recruitment and retention issues, and in particular, that we would welcome evidence from the Health Departments on the size of the workforce needed to produce the level of dental care they felt appropriate. The Department of Health's evidence this round indicates that the workforce review has concluded that some additional growth in workforce numbers is likely to be needed and that as a short-term solution, it would be looking to recruit more dentists from overseas. It would also be increasing the number of training places for professionals complementary to dentistry. While we accept that work is going on to look at demand drivers, such as patient recall, and so it may not be possible at the present time to be clearer about the relationship between the workforce and the level of dental care needed by the NHS, this still leaves us in a position where we are unable to judge whether the NHS might be under-resourced with regard to GDPs because we have nothing to measure the current workforce against. In the absence of any official indication of the size of the workforce needed, anecdotal evidence about the difficulties of finding an NHS practitioner in certain parts of the country, such as the well publicised examples of events in Carmarthen last July and Stonehaven last January, will inevitably set the background for any consideration about recruitment issues.*

- 3.41 *Both the Department of Health and the BDA acknowledge again this round that retention is a problem for the GDS at the present time, although, as in the last round, the size of the drift away from the NHS towards private practice remains unclear to us. The BDA has attempted to offer some quantification, whereas the Department of Health presents none. We were concerned about this drift away from the NHS in the last round and we remain concerned. Our remit requires us to have regard to the retention of our remit groups, but it is difficult for us to judge how seriously to view the drift away from NHS dentistry without firstly, some reliable evidence about its scale, and secondly, without knowing what size of workforce the Health Departments wish to maintain. We note that the Department of Health has said that "The NHS cannot be drawn into a bidding war with the private market over pay rates". The issue of the differential between the feescale for private work and that for NHS work was discussed at our oral evidence session with the Minister and he accepted NHS dentistry's failure to compete effectively for the services of the workforce. We accept the point that to compete effectively with rates that can be earned in private practice would require very substantial increases in the feescale and the affordability aspect of our remit would preclude any recommendations on our part which achieved such an alignment. One reason for the growth of the private market seems to be the failure of NHS dentistry to provide sufficient services to meet the demands of its customers. The Department of Health has said in its evidence, however, that the Government remains committed to NHS dentistry and the Minister told us that he wished to reverse the decline and expand NHS dentistry. We must therefore consider what recommendations we can make which will offer some support in retaining practitioners within the NHS and helping their morale while the Department's programme of reform is taken forward. This consideration forms the background to our recommendations for GDPs this round.*
- 3.42 *We would note here the Department's evidence that the question of morale needed to be viewed with some caution against the background that dentists in most parts of the country appeared to be sharing in the growth in the private market. However, the move out of NHS dentistry is as likely to be a reflection of low morale amongst practitioners as a wish to share in the benefits of an expanding private dentistry sector. And of course, we would also not wish the Department to lose sight of those practitioners who remain highly committed to the NHS and those for whom private practice is not an economically viable option. The commitment, at whatever level, of those GDPs operating within the NHS is a valuable resource which we are required to support, within the other constraints of our remit. We said in our last report that we regard it as essential to encourage GDPs' retention in the GDS while the parties work towards reforming the service. This remains our view.*
- 3.43 *We note again this round the changes that have been made in Scotland which the Scottish Executive Health Department hopes will recruit and retain dentists in the GDS in Scotland. As we said in our last Report, we would very much welcome evidence on the impact of these measures on the recruitment and retention situation in Scotland. When this is available, we would also welcome the views of the Department of Health and the National Assembly for Wales on whether any of the Scottish measures might be adopted in England and Wales. We would also welcome further evidence from the National Assembly for Wales on developments within the GDS in Wales.*
- 3.44 *We acknowledged in the last report the Department's point that only major reform of the remuneration system could get to the heart of matters which were causing low morale – namely, the belief amongst GDPs that their work was too intensive, which was often referred to as the 'treadmill effect'. We also said that we hoped that a reduction in the 'treadmill effect' would help to improve retention and morale. We therefore note that the Department of Health has said that "...the Government has taken steps to ensure that the item of service fee arrangement – the much reviled treadmill – will go as part of the move to local commissioning, thus delivering from day one of the new arrangements the change which the*

profession have been urging most keenly.”. We welcome this statement, although it is unclear to us how this will be achieved when the Department has also said that the new base contract will apparently require broadly comparable levels of work for broadly the same level of current gross income (uplifted by our recommendations). We will look for evidence in due course that the new arrangements are delivering the benefits for morale and retention that we would expect. We hope that the Department’s argument that PCTs will be able to fund locally measures to support dental practices will prove correct, though we are concerned that PCTs in reality are likely to have many competing demands for funding.

Commitment payments and the “lag effect”

- 3.45 The **BDA** said that NHS dental treatments that were begun before 1st April (when a new feescale increase was normally implemented) were subject to be charged based on the previous feescale. It said that as practitioners undertook treatments started prior to any feescale increase they incurred a financial penalty that was positively related to the time spent in the new fiscal year undertaking such treatment. It referred to this as the “lag effect” and said it occurred on item-of-service claims following a feescale increase. It said that the “lag effect” also had repercussions on the level of commitment payments distributed to practitioners in the first fiscal quarter of each year. Thus, holding all other factors constant, a feescale increase on gross fees would result in a practitioner’s gross income rising by less than the feescale increase. The BDA said that it estimated that the “lag effect” of the 3.225 per cent rise in the feescale for 2003-04 was almost £4 million. It said that to compensate for the “lag effect”, any actual feescale increase needed to be increased by 7.43 per cent of the intended feescale increase. The BDA asked that any feescale award on gross fees allowed for the “lag effect”.
- 3.46 In supplementary written evidence, the **Department of Health** said that the BDA had raised the issue of the “lag effect” with us in the 1990s, when we had said in our Twenty-Sixth Report that dentists should receive financial compensation where the feescale applicable to a course of treatment was more than one financial year out-of-date. The Department said the intention was that dentists should receive additional increases so that they were never more than one feescale in arrears. It said that our Twenty-Seventh Report in 1998 had noted that “the Department have implemented a scheme to compensate dentists which is in line with the main thrust of our recommendation”. The Department said that in a financial year just over three-quarters of adult treatment and half of children’s treatment was paid for under the feescale applying from the start of that year, with the rest paid for under the previous year’s feescale. It said that it considered the current arrangements provided the appropriate fees for treatments covered in the previous year and that the changes proposed by the BDA were not justified, nor the best use of scarce resources. It said that to use the current year’s feescale for all courses of treatment in 2002-03 would have cost an extra £12 million each year in England.
- 3.47 The Department noted the BDA’s comment that the “lag effect” affected the amounts paid out under the Commitment Payments scheme, but said that the scheme had been constructed initially so that a certain amount was paid out each year, starting with £20 million in the first year in Great Britain. The Department said that if dentists’ gross fees had been raised because of the inclusion of additional payments for the “time lag effect”, other aspects of the scheme would have to have been changed in order to deliver the set £20 million.
- 3.48 The **BDA** said that it welcomed the strengthening of the Commitment Payments scheme in 2003-04. It said that it fundamentally believed that the scheme was effective in stabilising practitioners’ levels of commitment to the NHS.

Comment

- 3.49 *The BDA has asked us to take into account the “lag effect” in any feescale award on gross fees. We considered this issue in our Twenty-Sixth Report and made our recommendation accordingly. We do not intend to re-open the matter at this time and particularly when, in England at least, we are entering the final year of the current system of remuneration for GPs working within the GDS. However, we would expect the future arrangements for local contracting to seek to avoid any significant financial disadvantage arising for practitioners as a consequence of the way in which the annual funding uplift is implemented. We would ask the National Assembly for Wales and the Scottish Executive Health Department to bear this in mind as well as they consider any future changes to their own arrangements for NHS dentistry.*
- 3.50 *In our last report we noted that the parties had been unable to provide definitive evidence on the effectiveness of the Commitment Payments scheme, that we recognised that better quality evidence about the effects of commitment payments was desirable and that we were putting this in hand. In preparation for a full quantitative study, we asked our secretariat to commission a qualitative study to explore the main drivers affecting commitment to the GDS, to gather views on how effective commitment payments were at retaining GPs in the GDS, the effect commitment payments have had on GPs’ motivation to practise in the GDS, and GPs’ views on what improvements could be made to the scheme to increase its effectiveness in retaining GPs in the GDS. This has been done using BMRB Social Research and their report has been shared with the Department of Health and the BDA for information. An executive summary of the report can be found at Appendix G and a summary of the Department of Health and the BDA’s responses to the report are at Appendix H. The full text of BMRB’s report is available on the OME website – www.ome.uk.com. Because of the short period of time that has elapsed between the last and present rounds, a full quantitative study to check the robustness of the evidence gathered from the qualitative study has not been possible.*
- 3.51 *We have noted the results with interest, but in view of the limited nature of the study carried out by BMRB, do not consider that it provides us with sufficient evidence on which to base any further decisions about the Commitment Payments scheme. In previous years, in addition to recommending increased funding, we have recommended that funding for the Commitment Payments scheme be uplifted in line with our general recommendations. Consistent with that approach we **recommend** (recommendation 7) that the scheme is uplifted in accordance with our general recommendation for GPs this round, as set out in paragraph 3.99.*

Seniority payments

- 3.52 *The BDA said that there was concern at the failure to retain older and more experienced NHS practitioners within the NHS. Since April 2003, practitioners up to age 70 (previously 65) could continue as GDS principals, but the BDA said that this had no real impact if practitioners had already left the NHS or the profession as a whole. Under the present remuneration system, seniority payments and practitioners’ entitlement to commitment payments ceased for those practitioners who started to draw their pension. The BDA said that this system acted as a significant disincentive to retaining such practitioners within the NHS. The BDA said that we had recognised this anomaly for general medical practitioners (GMPs), when we recommended that from April 2001, there should be a seven per cent increase in GMPs’ seniority payments. This was stated to be an integral attempt to improve GMPs’ motivation, recruitment and retention. Since then, the seniority payment scheme for GMPs was to be improved further, to deliver a 30 per cent increase in total resources over current spend by 2005-06, based on years of NHS service.*

- 3.53 The BDA said that although senior practitioners (i.e. aged 55 and over) received incentive payments (through seniority payments and commitment payments) of £11,215, it said that the conditions to receive such payments included grossing over £129,000 and having 1,650 registered patients. However, it said that generally, senior practitioners tended to gross less than this because of the age factor and physical limitations, and that as a result, levels of both commitment and seniority payments dropped. The BDA asked us to recommend that a GDP who opted to take their pension at age 60, but who continued to work, should not lose their entitlement to seniority payments or commitment payments.
- 3.54 The BDA said that the current system of seniority payments in England for practitioners allowed a maximum payment of £7,049 in 2003-04. However, in Scotland, the maximum payable from April 2003 had risen from £7,000 to £13,000. It said that the Scottish Executive believed it would enhance the retention of dental practitioners with an aim of improving access to NHS dentistry across Scotland. It therefore asked us to recommend that the maximum payments for seniority be raised to the same level as for Scottish GDPs and for it to be eventually brought in line with the GMPs' seniority scheme.
- 3.55 In supplementary written evidence, the **Department of Health** said that should a dentist already drawing an attractive public sector pension return to GDS work, it would be an unreasonable use of taxpayers' money to 'top-up' fees earned to compensate for the fact that output might not be as high as that of a younger dentist. It said that seniority payments in England and Wales currently amounted to some £5 million a year, with some 900 dentists a year receiving payments. Extending those payments to dentists who were drawing pensions would cost about £2 million a year in England in Wales. The Department said that it did not consider that would be appropriate. In terms of differences in seniority payments in Scotland, it said that dentists providing general dental services in England would have a legal right to be offered a GDS contract from April 2005, which included a three year protection of gross earnings, so from that date earnings would not be directly dependent on maintaining output.

Comment

- 3.56 *We have seen no evidence that GDPs who decide to draw their NHS pension are also leaving the NHS or reducing their commitment to the service. As we are required to balance the interests of the taxpayer against those of our remit groups, we see no justification for recommending that GDPs should retain their seniority and commitment payments once they start drawing their NHS pension.*
- 3.57 *In our last report, we asked for evidence from the Scottish Executive Health Department on the effectiveness, with regard to retention, of extending seniority payments in Scotland. As yet, there is no evidence available for us consider and so our decision remains as previously that for now, we do not consider that we should recommend the same approach for England and Wales.*

Remuneration

- 3.58 The **BDA** said that last year, we had asked the parties for an agreed estimate of total remuneration for whole-time equivalent (WTE) GDPs. Uplifting the results given in OME's Workload Study of 2000, the BDA said that in 2003-04, the personal gross fee earnings for a full-time wholly committed NHS practice owner was £138,000 and for an associate was £116,000 (including expenses and tax). The BDA said that its information was that in 2002-03, there were around 13,000 WTE GDPs. It said that the number of WTE GDPs as a proportion of the dental workforce (for England and Wales) had

continued to decline, and that the effective dental workforce dedicated to NHS work, in terms of the number of WTE GDPs, had fallen from 98 per cent in 1992-03, to 67 per cent in 2002-03. It said that this was despite continued increases in the absolute size of the workforce, and that it was imperative measures were taken now to stabilise the current NHS commitment of GDPs.

- 3.59 In supplementary written evidence, the **Department of Health** said that dentists did not have a standard working week, and were free to vary both their working hours, their work and the support which they received from other staff. It said that one way of defining WTE was in terms of average gross earnings. Those gross earnings included both payments for dentists' time, but also payments to meet expenses including wages and salaries of staff and payments for laboratories. It said that estimated average gross fee earnings in 2002-03 for dentists with gross earnings of £55,600 or more was £136,632. Dividing total gross fees by the estimate of average earnings for the three years 2000-01 to 2002-03 gave estimates of the number of WTE GDPs in England of 11,510 (2000-01), 11,480 (2001-02) and 11,300 (2002-03). It said this indicated an estimated drop of around 200 WTE dentists in the two years 2000-01 to 2002-03, or a reduction of less than two per cent.

Comment

- 3.60 *We commented in our last report that we had been seeking to establish an acceptable and agreed estimate of total remuneration for WTE GDPs for some time as we felt that the information would be an important addition to our deliberations on this group. We pointed out that we were concerned that we still did not have this information and were having to rely instead on separately derived figures. This round, the parties have chosen to draw conclusions about the decrease in the size of the workforce from information about gross fee earnings. We would stress to the parties again that we see an acceptable and agreed estimate of total remuneration for WTE GDPs as important information for our deliberations, even under the new arrangements. We therefore **recommend** (recommendation 8) that their work on reforming the GDS takes this information need into account, so that a reliable and agreed baseline for the remuneration of WTE GDPs fully committed to the GDS can be established for the reformed GDS, which can then be updated each round. We would ask the parties to report progress on this for the next round.*

Expenses

- 3.61 The **BDA** said that its Dental Business Trend Survey (2003) showed that 41 per cent of dental expenses were salaries and wages; 16 per cent were attributed to laboratory costs; dental consumables accounted for 14 per cent; 11 per cent related to premises costs; and 18 per cent related to other non-capital expenditure. The BDA said that one of the major stumbling blocks to the acceptance of the three-year pay offer had been the issue of expenses and dental inflation, with the 3.225 per cent increase for 2003-04 being insufficient to cover the expense element of most committed NHS dental practices. It said that wages and salaries for Professionals Complementary to Dentistry (PCDs) in isolation had increased overall practice expenses by between 2 – 2.5 per cent annually. Furthermore, the tightness of the labour market for PCDs was driving the upward pressure on wages, with practices more committed to NHS care finding it relatively more difficult to maintain PCD pay at levels that attracted or retained staff. The BDA said that it estimated that dental expense inflation was to rise by 4.3 per cent for 2003. It said that practitioners faced many other factors adding upward pressure on overheads and expenses: the increase in the General Dental Council (GDC) retention fee, which was to rise by a further 46 per cent between 2003 and 2005; and professional indemnity cover, for which one provider offering professional indemnity to around 70 per cent of UK practitioners, had increased their fee by 57 per cent between 2001 and 2003.

- 3.62 The BDA said that we had been repeatedly misled by the Department on the interpretation of the annual Inland Revenue survey on practice expenses. It said that the fall in the expenses ratio since 1990-91 was due predominantly to the shift towards private practice and not that practitioners were spending less. The BDA gave examples of practices in Manchester and West Yorkshire where expenses had risen. It said that practice expenses had been rising and most of the burden had fallen upon the practice owner. Fee scale increases had not taken account of dental inflation adequately and regional pressures upon expenses could not be addressed through such a mechanism. Consequently, it said that patient care, particularly in terms of the time patients wished to spend with the practitioner, was being compromised as practitioners struggled to replace both staff and equipment. The BDA therefore asked us to recommend that any feescal rise acknowledged the estimated 4.3 per cent rise of dental inflation for this year, and that we recommend an increase in the feescal of 4.1 per cent. It also asked us to recommend that a review be undertaken of GPs' expenses with the view to having a system in place by 2005 that could adequately deal with differing regional expense pressures.
- 3.63 The **GDPA** said that inflation within dentistry had been well above the pay award of 3.225 per cent. It said that the National Average Earnings increase over the last twelve months was 5.6 per cent.
- 3.64 In supplementary written evidence, the **Department of Health** said that the BDA's assertion that dental inflation was higher than general inflation was based on the results of the BDA's Professionals Complementary to Dentistry (PCD) Survey (2003). It said that PCDs were mainly therapists and hygienists and there were relatively few in the GDS. Pressure on their salaries was mainly in attracting them to private work as hygienists. It said that in the GDS, dentists might use PCDs to substitute for their own time which although increased expenses, would lead to an increase in gross fees earned. The annual income and expenses survey indicated that dentists' income to expenses ratio was relatively stable, with the estimate for 2001-02 of 55.6 per cent being similar to the 55.7 per cent ratio in 1993-94. The Department said that the BDA claimed extra private working decreased the expenses ratio. To investigate the effect of increased private working, the Inland Revenue results for individual dentists could be reweighted by the amount of GDS work they did. The Department said this showed that NHS earnings weighted results produced an expenses ratio only two percentage points lower than the results covering all dental work.
- 3.65 The Department said that expenses varied between dentists and would show local variations, dependent on wage and premises costs. The Department reminded us that as part of the three-year pay deal offered to the profession in preparation for local contracting in 2005, it had proposed to look jointly at how expenses could be more sensitively reflected under local contracting and, if possible, to make some progress in advance of 2005. Under the local contracting arrangements for dentistry, it would be possible for PCTs to agree with their providers more sensitive ways to reimburse expenses which better reflected regional expense pressures. The Department said that it would make no sense for such local arrangements to be directed centrally in advance of the new arrangements.

Comment

- 3.66 *The parties have provided conflicting evidence this year on the true impact of dental expenses. Since the abandonment of Target Average Net Income (TANI) in 1994 there has been no agreed mechanism for trying to monitor or forecast the trends in dental expenses. We urged the parties at that time to give the utmost priority to the development and*

*implementation of a new remuneration system for GPs. This has not happened (though the new contracting system will be introduced in April 2005) and so there has been no agreed evidence on which to base a recommendation which takes account of changing dental expenses. We asked the parties in our last report to address the question of expenses as part of the work to develop new methods of remuneration under Options for Change, and we therefore ask for a report on progress here for the next round. Expenses are of concern to us and we therefore **recommend** (recommendation 9) that they are given proper consideration under the new regime.*

- 3.67 *The Department has told us that under local contracting arrangements, it will be possible for PCTs to agree with their dentistry providers more sensitive ways to reimburse expenses which better reflect regional expense pressures. This may be a solution, providing PCTs have sufficient scope within their overall funding envelope to address such pressures. However, as we commented earlier in this chapter, we are concerned that PCTs in reality are likely to have many competing demands for funding. We would ask the parties for further evidence about developments here for our next review.*

Capital support and return on capital

- 3.68 The **BDA** said that many dental practices committed to the NHS were finding that they were becoming less and less viable, with rates of return approaching zero – consequently, NHS practices were difficult to sell on, with some simply closing. It said that practice owners that were highly committed to the NHS were less likely to maintain practice investment plans than private practices. However, it said that bodies corporate, such as James Hull and Associates and Oasis, were currently investing in high quality, modern practice facilities. It said this was to attract practitioners and provide high standards of care and choice for patients. The BDA said it was important to note that both the companies provided NHS treatment. However, bodies corporate could utilise innovative methods of acquiring capital support, such as access to funds from the stock market and venture capital, which was denied to high street (non-branded, non-corporate) dental practitioners.
- 3.69 The BDA said that the NHS Local Improvement Finance Trust (LIFT) scheme had proved to be problematic in delivering adequate capital support in a realistic business manner. It said that the heavy involvement of private stakeholders had resulted in vastly increased premises rental costs: it gave an example of a Manchester practitioner that had been offered LIFT premises that increased rental costs three-fold. It also said that LIFT did not contribute towards equipping practices. Therefore, practitioners were faced with significantly increased expenses without a corresponding increase in turnover, which were borne entirely by the practice owner. The BDA mentioned other problems with LIFT: uniform rental rates across sub-regions; practitioners losing the patient goodwill when they sold their current practice to move to new LIFT sites, as the practice valuation was based solely on the value of the land; the lack of transparency of how and which practitioners were selected for inclusion in LIFT; and considerable problems finalising agreements regarding the repayment of capital costs between the various stakeholders. It said the outcome was that the dental profession was not accessing much needed capital support.
- 3.70 In supplementary written evidence, the **Department of Health** said that it understood the current difficulties with dentists' inclusion in LIFT schemes. It said that a key aim of LIFT was to meet the costs incurred by practitioners moving from inappropriate premises into modern, purpose built premises, preferably co-located with other primary care providers. The Department said its view was it was essential to move to a contractual arrangement where the premises cost of the overall expenses envelope could be identified so that premises costs could be considered separately, and this might require

some additional support from primary care organisations locally. Proposals were under consideration in a number of areas from dentists who wished to move their practices into PDS so that the predictable levels of gross earnings would enable them to join LIFT schemes. Practice turnover would be predictable universally post 2005. In addition, the Department said that the new legislation provided for PCTs to offer assistance and support, including financial support, to providers under both GDS and PDS contracts. The Department said that the National Audit Office was undertaking a review of LIFT, and it had made the same points to them in early November.

- 3.71 The **BDA** also said that the financial world did not view NHS dentistry as a financially viable proposition compared with private dentistry, in view of the fact that between 1998 and 2002, both banks and accountants had been continually advising practice owners to increase the number of private patients and to reduce the number of NHS patients seen.
- 3.72 In its 2002 Survey of Welsh GDPs, the BDA said that almost one in five of practitioners in Wales intended to retire in the next five years. Of those, one in four felt that their practice would not exist after their retirement. Where practitioners had been trying to sell their practices, almost half had been trying to do so for more than 12 months, with a quarter trying for over 24 months. It said that losing practices providing NHS care could not be in the public interest at a time when people could not access NHS practitioners. The BDA told us that in Carmarthen this year, over 600 people queued to register with an NHS dentist. It also said it estimated from its research that over 100 NHS dental practices had closed across England and Wales in the last two years, due to an inability to sell them on.
- 3.73 The BDA said that these issues had manifested themselves as negative perceptions in the next generation of practitioners. Historically, a career pathway for a new GDP would involve becoming a practice owner. However, the proportion of associates attracted to becoming a practice owner had been declining since 1998. It said that the reasons for this included an unwillingness to accept the debt of a practice against its future financial rewards; uncertainties surrounding NHS dentistry making it difficult to obtain backing from financial institutions; and the continuing and increasing NHS bureaucracy. Additionally, the structure of the dental workforce was changing along with their aspirations. The BDA said that for the Health and Social Care Bill in England to successfully deliver the vision of NHS dentistry outlined in *Options for Change*, it would need a motivated NHS workforce and practices in which to deliver NHS dentistry. It said there was no guarantee that either would exist in 2005 and beyond, and that the picture was bleak.
- 3.74 In its evidence, the **GDPA** asked us to recommend an increased modernisation budget of £2 per head, available to all practices that retained 2,000 patients, for investment.
- 3.75 In supplementary written evidence, the **Department of Health** said that practices needed to change to reflect shifts in the population. Larger practices had the potential for economies of scale and the total number of dental practices had been increasing.

Comment

- 3.76 *We note the BDA's evidence regarding rates of return on dental practices, the difficulties with the NHS LIFT scheme and the consequent difficulties in accessing capital support, and the impact these factors are having on GDPs' willingness to become a dental practice owner. We also note the GDPA's request that we recommend funding for modernisation. We must repeat our view, set out in previous reports, that we do not consider capital support to be strictly a remuneration issue and therefore it is not within our remit. However, we would also say*

again that we welcome any funding that the Health Departments put towards modernisation of practices, as this should help morale, and that the Departments should continue to bear in mind the retention, morale and motivation effects of any assistance with capital support. As Ministers have made clear their strong commitment to modernising NHS dentistry and integrating it within the wider NHS, we expect there to be sufficient provision for adequate capital support going forward into the new regime. This may require consideration to be given to the provision of further capital funding, beyond what has already been announced by the Department of Health.

- 3.77 *We noted last year that the framework agreement on Options for Change said that one of the changes it wanted to deliver was “fair reward for capital investment in the NHS”. We still consider this to be very important and would ask the parties for evidence in the next round on progress in taking this forward.*
- 3.78 *For the next round, we would also ask the parties for evidence on the deployment of the £35 million capital funding announced by the Department last September for use in 2003-04 and 2004-05. We consider it important that this funding should be fully spent over these two years, and we would also expect the funding to be targeted at those practitioners with the greatest commitment to the NHS and the greatest need for support.*

Practice cost allowance

- 3.79 The **BDA** said that up to ten hours a week were spent undertaking administration. It said that the ever growing administrative burden affecting NHS practitioners led to reduced clinical hours being delivered by the workforce as a whole, thus exacerbating problems with access and restricting patient care and the time practitioners could spend with patients. The burden also had an impact on the turnover and profitability of NHS dental practices, and were also seriously affecting practitioners’ morale. It said that relieving a full-time, wholly committed GDS practitioner of the administrative burden would allow them to increase the amount of clinical time spent with their current GDS patients by 15 per cent, or allow practitioners to reduce their workloads. The BDA noted that for larger practices, a practice manager could help improve profitability. The delegation of practice management to another individual led to increased turnover and greater control on costs. However, this was only viable for larger practices due to the shortage of managers and the cost of employing them.
- 3.80 The BDA said that the introduction of a practice allowance for practitioners would improve NHS dental services for patients and would help to address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support, information collection and provision. It would also, it said, contribute to the retention of practitioners within the NHS. A banded practice allowance based on gross earnings would be, it claimed, simple and transparent to introduce. The BDA therefore asked us to recommend that a practice allowance of up to £3,000 be introduced, pro rata, to GDS practice owners.
- 3.81 In supplementary written evidence, the **Department of Health** said that dentists’ fees covered both their income and expenses which included administrative costs. In its view, the move away from item-of-service remuneration, coupled with protected gross earnings, would allow dentists and practice staff to undertake practice management without an impact on gross earnings. It said that as part of the assistance and support which the new legislation enabled the PCT to offer its providers, it was expected that practice management expertise would be made available by the PCT, particularly for smaller practices. The Department also said that from a practical point of view, new procedures would be needed to make payments for practice allowances, since Dental

Practice Board data did not identify practice owners. Such a proposal might appear to non-practice owners as divisive and would be a complicating factor in determining allocations to dentists. The Department said that its view remained that new investment was most effective when used locally to support local needs. It also said that the situation in Scotland was different, and it would be useful to see the evaluation of the Scottish arrangements. It said that the costs of a £3,000 practice allowance would be some £20 million to £28 million a year, depending on whether there was an adjustment for different levels of NHS commitment.

- 3.82 In our last report, we had asked the Welsh Assembly to consider testing a practice allowance in Wales. The **BDA** said that to date, no approaches had been made to the General Dental Practice Committee (GDPC) in Wales with a view to undertaking such an exercise.
- 3.83 In supplementary written evidence, the **Department of Health** reported that the National Assembly for Wales had discussed practice allowances with the Welsh GDPC, and although no decisions had been made, negotiations would continue.
- 3.84 The **GDPA** also asked us to recommend a practice allowance of an additional £5 per patient for a limit of 2,000 patients, to be phased in by April 2004.
- 3.85 In supplementary written evidence, the **Department of Health** said that the GDPA's proposals seemed similar to the Commitment Payments scheme which had been increased year on year to encourage dentists to register more patients. It said it was not immediately apparent why the proposed 'capitation' additions would be more successful. It said that further complication of the payment system during the shadow year 2004-05 would reduce the stability of the GDS and jeopardise the ability to inform both PCTs and dentists of their allocations for 2005. The Department said it would want new resources to be used in a targeted way to support local services.

Comment

- 3.86 *We noted in our last report that the Options for Change framework document had said that a key theme for early exploration would be the option of testing a basic practice allowance to offset some of the fixed costs of running a dental practice. We also noted that the BDA had given its support to the need to test out the ideas in Options for Change before any national introduction. We therefore did not consider it appropriate at that stage to recommend the national introduction of a practice allowance, but instead asked the parties to accelerate their work on a basic practice allowance and to set up urgently a number of pilot sites at which an allowance could be tested. This remains our view, particularly as no evidence is available as yet about the effect on recruitment or retention of the introduction of a practice allowance in Scotland. We would therefore repeat our request for the parties to take forward work on testing out a practice allowance at the Options for Change field sites and to report to us in the next round. We would also ask for evidence from the National Assembly for Wales on progress in considering the introduction of a practice cost allowance in Wales.*
- 3.87 *We note here the Department of Health's evidence that the new legislation will enable PCTs to offer their providers assistance and support, including making practice management expertise available, and that new investment was most effective when used locally. We would repeat again the point we made earlier in this chapter that PCTs in reality are likely to have many competing demands for funding. We would therefore ask the parties for further evidence for our next review about the development by PCTs of arrangements for this kind of local support.*

Other funding/allowances

- 3.88 The BDA also said that the Department had ring-fenced £59 million for modernisation funding (in England), and in 2002-03, the Welsh Assembly Government had made £900,000 available for the refurbishment of dental practices in Wales. However, it said that no funds had been identified for use in the current financial year.
- 3.89 The BDA said that in 2004-05, GDPs in England and Wales would need to attend meetings with Trusts to learn about new systems and new ways of working in preparation for the changes envisaged by the new Health and Social Care Bill. It said they would also need to hold practice meetings and arrange training sessions to familiarise staff with the new arrangements. These meetings would be at the expense of clinical time for which there would be no reimbursement. The BDA said the shortfall could be addressed by raising the number of Continuing Professional Development (CPD) sessions which could be claimed (for one year only) in England and Wales. It estimated that a total of six sessions would be necessary for the additional training and information sharing to take place. It therefore asked us to recommend that the number of CPD sessions that could be claimed in 2004-05 was raised by six sessions and that a training grant of £1,000 be made available, for one year only, to go the practice owner, to enable staff training.
- 3.90 In supplementary written evidence, the **Department of Health** said that the underlying principles of the new contracting regime from 2005 was a move away from a highly regulated, rules based national contract to something significantly simpler. It said that it was the Department's view, and its aim, that dentists and their staff would find the new arrangements transparent and easy to interpret and so they would readily adapt to the new world.
- 3.91 The **GDPA** said that GDPs were discriminated against as they were not eligible for London weighting, unlike hospital medical and dental practitioners. It asked us to make a recommendation that London allowances be paid to London GDPs.
- 3.92 In supplementary written evidence, the **Department of Health** said that London was not the only area where expenses might be above average, but that gross earnings of dentists practising in London were also significantly above average. It said it had sympathy with the concept of regional variation to more accurately reflect variation in elements of practice expenses, such as premises or wages. However, it said that a redistribution within the current national framework would be a blunt weapon and would inevitably lead to unfairness. Under local contracting however, it said it would be possible, over time, for commissioning PCTs through more direct reimbursement to reflect more accurately local differences in expenses.

Comment

- 3.93 *We note the Department of Health's view that the new arrangements will be transparent and easy to interpret and so dentists and their staff will readily adapt to the new world. We also note the modest funding of £1 million which has been set aside to cover organisation development in 2003-04 and 2004-05 for PCTs, local dental committees and dentists in readiness for the new regime. In our view, even if the new regime is transparent and easy to interpret, a structured change management programme will be needed for dentists and their staff to prepare them for the new arrangements. We consider that the funding of £670,000 for 2004-05 is likely to be inadequate and would therefore **recommend** (recommendation 10) that the Department of Health consider making available a more appropriate level of additional funding, which should be targeted locally through PCTs, in support of a structured*

change management programme. The BDA has suggested increasing the number of CPD sessions that can be claimed in one year as a way of providing additional training and information sharing about the new regime. We would make the point here that CPD is a mandatory requirement of the regulatory bodies, and is not an appropriate vehicle for providing training for organisational change.

- 3.94 *The GDPA has asked us again to make a recommendation on a London allowance. We have said in previous reports that we do not intend to make arbitrary changes to the existing feescale and this remains our position. We note here that the Department has said again that under local contracting, it will be possible for PCTs through more direct reimbursement to reflect more accurately local differences in expenses. As we said earlier, this may be a solution, providing PCTs have sufficient scope within their overall funding envelope to address such pressures. We would ask the parties for further evidence about developments with PCTs offering local support for our next review.*

Level of fees increase

- 3.95 The **Department of Health** said that it remained committed to NHS dentistry and had put in place the necessary process and investment to deliver the legislative change necessary to give the NHS locally the levers and supporting resources for NHS dentistry, and to support NHS dentistry during the transition. It said that whilst recognising the legitimate concern of the profession that there should be “no big bang” in introducing change, it had taken steps to ensure that the item-of-service arrangement – the much reviled treadmill – would go as part of the move to local commissioning, thus delivering from day one of the new arrangements the change that the profession had been urging most keenly. The Department said that the increase in fees should be set at 2.5 per cent, consistent with the Government’s inflation target, to provide stability and maintain comparability with similar groups. It also commented that additional funds for NHS dentistry were most effective when targeted through the NHS locally and that increases in gross fees or allowances had not managed to reverse the trends away from NHS dentistry to any marked degree. It said that delivering on the reforms, improving dentists’ working lives and giving flexibility to PCTs and dentists locally to develop and improve services to patients remained its preferred approach.
- 3.96 In supplementary evidence, the Department said that the GDS remuneration system was complex and incentives already existed for dentists to alter their practice profiles in advance of local contracting in 2005. The Department said that a period of stability in the financial year 2004-05 would be in the best interests of dentists to ensure a smooth transition to the new arrangements from April 2005.

Comment

- 3.97 *We have made our deliberations this round against a background of a continuing reduction in GPs’ commitment to the GDS and the knowledge that a new regime will be in place for NHS dentistry in England from April 2005. We were heartened to see in the Department of Health’s evidence that Ministers had made clear their strong commitment to modernising NHS dentistry and integrating it within the wider NHS. The Minister confirmed this to us again in oral evidence and indeed his desire to reverse the decline in NHS dentistry. We therefore see a need for some acknowledgement of the retention difficulties this year through our pay recommendation.*

- 3.98 *In considering this, we have had regard to the fact that there is no pay drift for GDPs, because they are not paid on an incremental payscale, and the fact that GDPs have to meet their expenses out of the feescale. While we very much hope that the treadmill of the item-of-service feescale will go from day one (as the Department says), as we commented earlier, it remains unclear to us how this will be achieved when the new base contract will require broadly comparable levels of work for broadly the same level of current gross income (uplifted by our recommendations).*
- 3.99 *Taking all these considerations into account, and having looked at the parties' various proposals for action, our view is that our recommendation for 2004-05 should include a small real terms increase in the feescale. While we realise that a small real terms increase will have little effect in closing the gap between NHS and private dentistry earnings, we hope that it will go some way towards stabilising the retention of GDPs in the GDS, particularly as we head into the new regime. We therefore **recommend** (recommendation 11) that gross fees for items of service and capitation payments should be increased by 2.9 per cent for 2004-05 for GDPs. We also **recommend** (recommendation 12) that sessional fees for taking part in emergency dental services be increased by 2.9 per cent.*

CHAPTER 4: SALARIED PRIMARY DENTAL CARE SERVICES

- 4.1 *This year, the parties have presented evidence to us on progress with the three-year pay deal that was agreed for staff within the Salaried Primary Dental Care Services (SPDCS) and to update us on the review of the SPDCS.*

Three-year pay deal offer

- 4.2 The **Department of Health** said that a three-year pay deal (3.225 per cent a year) was agreed last year for the SPDCS and the salary rates we recommended on that basis were implemented from 1 April 2003. It looked to us to recommend similarly on salary rates for 2004-05 to incorporate the second tranche of the three-year pay deal. The Department said that it had also been agreed that the salaried side would benefit from a share of the capital sums offered as part of the three-year deal. Consequently, a sum of £5 million was due and proposals on its use would shortly be put forward.
- 4.3 The **Scottish Executive Health Department** (SEHD) also said that it looked to us to recommend salary rates for 2004-05 to incorporate the second tranche of the three-year deal for the SPDCS.
- 4.4 The **British Dental Association** (BDA) provided us with a copy of the reversion mechanism to the three-year deal, and told us that the parties had agreed that the deal, if the parties were unable to agree, should be referred to us should inflation fall below 1.725 per cent or rise above 4.725 per cent. It asked for our willingness to participate in the process, should it be necessary. It also said that the exact mechanism through which £5 million of modernisation monies would be distributed to the SPDCS was yet to be agreed. It said the objective was to ensure that those services that had not had access to Personal Dental Services (PDS) funding would receive the majority of the additional funding. It said it welcomed the opportunity to agree to the three-year deal, as it enabled a degree of pay stability to be introduced to the service, helping with planning and creating stability during the Department's Review.

Comment

- 4.5 *As the second year of the three-year pay deal, we note that the parties have agreed a 3.225 per cent uplift on salaries and allowances for all dentists in the SPDCS to be applied across the board in 2004-05. We therefore endorse and **recommend** (recommendation 13) this and have calculated 2004-05 salaries on this basis and reproduce these in Appendix A. The BDA has provided us with a copy of the reversion mechanism to the three-year deal and asked for our willingness to participate in the process, should it be necessary: we are happy to do so, if required.*

Review of Salaried Primary Dental Care Services

- 4.6 The **BDA** said that it had carried out a survey to investigate the effect of *Shifting the Balance of Power* on the relative job demands and responsibilities of Clinical Directors, consultants in Dental Public Health and Dental Practice Advisors. The results of the survey showed a substantial increase in Dental Public Health consultant and Clinical Director workload. It said it would be recommending to the Department's Review of the SPDCS changes to the Clinical Directors' multi-service allowance as an interim measure to address the additional workload.

- 4.7 The BDA provided us with copies of the Terms of Reference for the Review, and its methodology. It said it awaited the outcomes of the Review with considerable interest, as it felt much was riding on it for staff, and it looked forward to making progress on many fundamental issues in the Review's Terms of Reference. It said that the context of the Review was aligned closely to the wider changes being discussed for the whole of primary care dentistry flowing from the *Options for Change* work and the subsequent Health and Social Care Bill¹. The Review would be conducted in two phases. The first, to report in spring 2004, would concentrate, in the context of preparation for Primary Care Trust (PCT) commissioned primary dental services, on issues of service organisation, management/leadership and size of services as well as pay, taking note of the issues raised in Mercer's report². It was hoped that some issues might be completed in time for implementation by April 2004. If that were the case, both parties would report agreement to us. The second phase would look at the medium term (2005-06 onwards – with the potential for a ten year vision) and report on competencies, role, education and training and career pathways by late summer 2004. Work would then be taken forward during 2004-05 on terms and conditions of service and pay for the workforce involved, including consideration of developing as part of mainstream medical and dental grades.
- 4.8 The BDA said that it would participate fully in the process and looked forward to the outcomes addressing some of the fundamental issues affecting the SPDCS, particularly in the context of equal pay legislation, given the likelihood of current salaried staff working alongside former general dental practitioners in newly established PCT contractual arrangements in 2005. It said that it was difficult to comment in any detail at this stage of the Review, but it would keep us informed of progress, and seek our agreement on any proposed changes.
- 4.9 The BDA said that reviews might also be conducted in Scotland, Wales and Northern Ireland. It had been advising caution to colleagues in the devolved administrations to ensure that the results from the Department's Review were completed before the outcome of those reviews were implemented. It said that whilst it agreed that there should be a degree of managed divergence in the devolved countries, it wished to see that divergence applied to issues that could be agreed with the profession did not fundamentally affect basic terms and conditions, which should remain equivalent across the UK.
- 4.10 The **Department of Health** said that as part of the three-year deal, it was agreed that a review of the SPDCS would be undertaken, chaired by the Chief Dental Officer in England. It said the work had now begun and gave us details of the process for the review.
- 4.11 The **National Assembly for Wales** said that it would commission a review of the Community Dental Services (CDS), PDS and the CDS/general dental services interface in Wales. The Review would be set in the context of the recent structural reforms of NHS Wales, *Routes to Reform*³, and the implications for dentistry of the Health and Social Care Bill. The review would assist the development of a clear future direction for the CDS and other salaried services in Wales. The Assembly said it had the power to implement pay,

¹ This was passed into statute as the Health and Social Care (Community Health and Standards) Act 2003 on 20 November 2003.

² *Research on Salaried Primary Dental Care Services Staff*, Mercer Human Resource Consulting, October 2002, Cm 5722

³ *Routes to Reform, A Strategy for Primary Dental Care in Wales*, Welsh Assembly, September 2002

terms and conditions for the CDS and other salaried dental services specific to Wales, but that it had been policy, through the UK Joint Negotiating Forum (JNF), essentially to negotiate and implement salaried dentist pay awards in line and parity with England. It had observer status on the high level Project Steering Group of the English Review of the SPDCS. It said that this would allow it to be well informed about the general progress of the Review. As parts of the Review relevant to pay, terms and conditions and career structures were published, these would be specifically considered by the Assembly from a Welsh perspective. The Assembly said it would then deliver its response on these issues through the Wales sub-committee of the UK JNF. It said that this would allow its Review to concentrate on addressing issues of service organisation, management and leadership within the Wales CDS, setting the contribution of salaried dentists within the overall context of primary care dentistry. It would determine value for money and aspects of service delivery, assessing both quantitative and qualitative outputs in relation to economy, efficiency and effectiveness. It said the Review would assess functioning of the service, identifying good performance, any under-performance associated with systemic defects, and made a review in Wales something that an independent organisation could more easily conduct and report to the Assembly. It said that a fundamental review of the extant guidance on the role of the CDS in Wales would best be done after the Wales Review had reported.

- 4.12 The **SEHD** said that Scottish Ministers continued to approve new salaried dentists' posts. There were now 103 approved salaried posts in Scotland (41 of which were vacant), including five Senior Salaried Dentist posts (four vacant) and eight Specialist Salaried Dentist posts (five vacant).

Comment

- 4.13 *We very much welcome the progress that has been made on the review of the salaried services and look forward to receiving further evidence next year. We would repeat our comments from the last review that we hope the outcome of the review will enable pay and grading considerations to be thoroughly considered. We were also grateful for the Welsh Assembly's evidence describing developments in Wales. We would hope to receive evidence from both Wales and Scotland for the next round regarding developments within the SPDCS in those countries.*

CHAPTER 5: OPHTHALMIC MEDICAL PRACTITIONERS

- 5.1 *This year, the parties again return to the issue of the setting of the sight-test and domiciliary visit fees, and whether the joint negotiation of a common fee for both optometrists and ophthalmic medical practitioners (OMPs) should continue.*

Recruitment and retention

- 5.2 The **Health Departments** said that between December 2001 and December 2002, the number of OMPs registered to provide General Ophthalmic Services (GOS) in Great Britain decreased from 754 to 674, and the number of optometrists increased from 8,692 to 8,812. They added that the GOS continued to attract adequate numbers of practitioners of good quality with appropriate training and qualifications. Demand for NHS sight tests had decreased slightly, with 11.2 million sight tests paid for by health authorities and health boards in 2002-03, compared with 11.4 million in 2001-02. Within those figures, the proportion of sight tests carried out by OMPs was around four per cent.
- 5.3 The Departments repeated their point from last year's evidence, that their surveys showed that the majority of OMPs practised part-time, and that the 2001-02 survey showed that 55 per cent of practising OMPs also held other appointments, mainly as hospital doctors.
- 5.4 The Departments said that in October 2002, an awayday had been held with stakeholders from the optical and medical professions, NHS bodies and the voluntary sector, to seek to identify ways forward in developing NHS eye care services. They said that since then, a Steering Group had been established to continue discussions and prepare proposals for the better integration of eye care services, making greater use of the skills available in primary care. The Departments were currently consulting on the first report of the Group.
- 5.5 The **Scottish Executive Health Department** said that it had pledged to introduce free eye checks for all before 2007.

The sight test and domiciliary visit fees

- 5.6 The **Department of Health** said that it had made an offer of a three-year ten per cent deal to OMPs' and optometrist representatives in July, which amounted to an increase of 3.225 per cent a year in NHS sight-test fees and domiciliary visit fees for the three years 2003-04, 2004-05 and 2005-06. The three-year package also included a review of the GOS to consider possible changes in response to the work on the NHS Eye Care Services and wider changes in the NHS. The package was supported by additional funds for continuing education and training from 2004-05. The Department said that the BMA had rejected the three-year offer and that it had informed the Department that it would be seeking an increase in the NHS sight-test fee in line with increases for general medical practitioners (GMPs) and consultants. The Department said that the increases for GMPs and consultants were linked to new contracts and it did not consider that there was a case for similar increases for OMPs for their sight-test work under the current arrangements, and in advance of any changes that might flow from the review of the GOS which it had proposed. The Department said it remained of the view that the same sight-test fee should be paid to both optometrists and OMPs for what was essentially the same work. It therefore proposed to offer the same level of fees to OMPs for 2003-04 and 2004-05 as for optometrists, once the position was resolved with optometrists.

- 5.7 The **Health Departments** said that whilst it welcomed the contribution that medically trained OMPs brought to the sight test and eye examination, they were satisfied that the service provided by optometrists met patients' primary eye care needs. Since optometrists continued to carry out some 96 per cent of NHS sight tests, they said that they believed that our recommendation about the joint negotiation of a common fee remained as relevant now as it was in 1998.
- 5.8 The **British Medical Association (BMA)** said that at November 2003, there had still been no agreement on the common NHS sight test fee payable to OMPs and optometrists for the year 1 April 2003 to 31 March 2004. It said the principal obstacle had been failure to agree a payment for continuing education and training, which would shortly be compulsory for optometrists. It said the delay in reaching agreement on the common fee was reason enough for us to resume recommending the fee. The BMA said that it was attempting to gather compelling evidence that optometrists were able to offset losses incurred in carrying out NHS sight tests by dispensing spectacles, and hoped to let us have it in time for the next review.
- 5.9 The BMA said that OMPs needed to receive a minimum increase in pay of five per cent from 1 April 2004 if they were to avoid losing ground against their comparators. It therefore invited us to recommend an increase in the OMP sight test fee within the range 5-15 per cent.

Comment

- 5.10 *As we have stated over a number of years, we have yet to see evidence which demonstrates the requirement for differentiated sight tests to be conducted by OMPs and by optometrists. We noted last year that, in principle, we agreed that the cost of the sight test fee should be covered by the fee and not subsidised by dispensing spectacles. However, no evidence has yet been provided to suggest that cross-subsidisation is taking place. We therefore feel that a unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and representatives of both the optometrists and OMPS, remains appropriate and **recommend** (recommendation 14) accordingly. Whilst we would welcome evidence that might lead us to take a contrary view, in the absence of any such evidence, we would ask that this issue not be brought to our attention for future years. We also hope that the parties will soon be able to reach an agreement on the level of the sight test fee for 2003-04.*
- 5.11 *We look forward to hearing more in due course on the work being taken forward to look at developing NHS eye care services, and particularly on whether it will affect the remuneration of any of our remit groups.*

Part III: Secondary Care

CHAPTER 6: DOCTORS AND DENTISTS IN TRAINING

- 6.1 *This year, the parties have raised a number of issues concerning doctors and dentists in training. The parties report on the new contract for junior doctors and how the European Working Time Directive continues to have implications for their working lives. The parties have asked us to consider the levels of the pay banding multipliers which are applied to the basic pay of junior doctors to recognise the out-of-hours commitment and intensity of posts. We have also been asked to look at career bottlenecks for specialist registrars, the position of flexible trainees, the problems created by student debt and the increase for London weighting.*

Recruitment, retention and morale

- 6.2 Commenting on the workforce numbers for 2002, the **Health Departments** said that house officer (HO) numbers had increased by 380 (wte) or 8.3 per cent; senior house officer (SHO) numbers had increased by 1,530 (wte) or 8.1 per cent; and numbers in the registrar group (mainly specialist registrars (SpRs)) had increased by 690 (wte) or 4.8 per cent. They said that this represented a significant increase in SpR numbers in the last year and was faster growth than in the previous year.
- 6.3 The Health Departments said that medicine and dentistry remained very attractive careers and were continuing to attract high levels of applications from those with the highest qualifications. They said that the four new medical schools accepting their first intake in 2002 or 2003 also received high numbers of applications for their places. The Universities & Colleges Admissions Service (UCAS) A level points system had been replaced by a new system of tariff points: for 2002 entry, the average tariff points for medicine and dentistry applicants were 406.7 and 375.3 respectively, compared with 275.8 for all subjects. They said that the higher profile given to NHS careers through national recruitment campaigns appeared to be encouraging more people to consider and apply for a career in medicine. They said that the latest data from UCAS showed that, after a period during the late 1990s when numbers declined, the number of UK applicants to study medicine at UK universities was now at its highest since 1986. There were 21 per cent more applicants to medical school for 2004 entry (as at 15 October 2003) than at the same stage last year and 55 per cent more applicants than at the same stage in 2001. They said that the confirmed UK intake figure for 2001 was 6,115 students, an increase of nine per cent over autumn 2000. Provisional figures for the autumn 2002 intake were 6,740 students, a ten per cent increase over autumn 2001.
- 6.4 The Departments said they were keen to reinforce this upward trend and to increase the diversity of applicants to medical school. They described the national recruitment efforts that were resulting in increasing numbers of people being encouraged to consider and apply for a career in medicine. They said that UK medical school places were planned to be 7,217 in autumn 2004, the highest figure ever, and were planned to increase to around 7,330 by 2005. As the number of applicants continued to increase, they said they expected no difficulties in filling the additional places, but said they would continue to monitor levels of applicants to medical school and to keep the position under review.
- 6.5 The Departments described the *Modernising Medical Careers* initiative, which they launched in February 2003, to consider the opportunities for streamlining medical training and increasing flexibility in medical careers to meet the needs of patients and the NHS. The proposals were for:

- all stages of training to be delivered through structured programmes;
- two-year Foundation Programmes to replace the existing HO year and first year of SHO training;
- a specialty by specialty review of the opportunities for developing new consultant roles and the most appropriate model of training to deliver such doctors;
- a move to competency-based assessment; and
- parallel reform of the non-consultant career grades (NCCGs).

They said the proposals would be tested and evaluated through pilot schemes in a variety of settings in the NHS.

- 6.6 The **Department of Health** said that for 2003-04, HO places were broadly in line with 2002-03. However, as a result of increases in medical school intakes, the numbers of HO posts required would increase significantly from 2004-05. It said that a working group had been established to consider the distribution of additional HO posts across England. Additional HO posts would be distributed to Workforce Development Confederation 'clusters', with the aim of producing a distribution of HO posts by 2010 which was as geographically equitable as possible, and of improving the educational effectiveness of the HO placement by allocating places as close to medical schools as possible.
- 6.7 The **National Assembly for Wales** said that a programme had been established to increase the number of doctors in training by 65 per cent. It said that during the last three years, the number of medical students in training had increased from 966 to 1,104 and would be increased to 1,385 by 2004. It said that SpR numbers were largely determined by the workforce plans, and that a process for the identification of additional posts to meet specific requirements had been established. Central funding had been provided for an extra 60 SpR posts between 2000 and 2003. It said that to accommodate the increased number of medical students, a clinical school had been established in Swansea. Further developments across Wales had been announced and were undergoing a business case approval process, such as the Swansea Graduate entry scheme and Clinical Schools in North Wales and Gwent.
- 6.8 The **Scottish Executive Health Department** (SEHD) said that in 2002: SpR numbers had increased by 202 (wte) or 16.26 per cent; SHOs increased by 196 or 8.5 per cent; and HO numbers increased by 88 or 12.23 per cent. It said it was committed to expanding the capacity of dental training facilities in Scotland by establishing an outreach training centre in Aberdeen and would be consulting further on the need for its development to a full dental school. It said that a review was underway that considered a number of aspects underpinning the provision of basic medical education, including:
- access to medical education in Scotland;
 - the number of medical school places;
 - the role of undergraduate medical education in improving the health of the people in Scotland;
 - the contribution of undergraduate medical education to the support and development of the NHS; and

- the possibility of fast-track graduate-entry medical degree courses.

It also told us about *Careers for Health*, and how it was looking at recruitment and retention issues.

- 6.9 The **British Medical Association** (BMA) said that the rise in applications for medical school places needed to be placed in the context of an increased number of medical school places. It said that places had risen by 50 per cent since 1997, and the number of applicants per place was still significantly below the 1997 level and that furthermore, 59 per cent of applicants to medical school were women, which suggested that the potential future increase in doctors would be lower in whole-time equivalent terms.
- 6.10 The BMA said that it was widely accepted that the recent and forthcoming changes in the NHS would require a drive towards the recruitment and retention of doctors. It said that doctors left the profession for a number of reasons: the BMA's Cohort study showed that since graduating in 1995, three per cent of the cohort (two males, ten females) had left medicine as a career, with the two most common reasons being dissatisfaction with medicine and the attractions of other careers. Other reasons were working conditions in the NHS, family commitments, the lack of research opportunities and poor training. The Cohort study also showed that the number of doctors expressing a strong or very strong desire to practise medicine had fallen by three per cent to 68 per cent; of the remaining 32 per cent, the reasons given for their dissatisfaction included a lack of available National Training Numbers (NTNs), the increased volume of work, declining pay and conditions, poor morale and a lack of a sense of cohesion across the medical profession. The BMA asked us to take all this into account when determining the pay award for junior doctors.

Comment

- 6.11 *The evidence from the Health Departments continues to show growth in the number of applicants to study medicine. This is very encouraging. Given the planned expansion of the NHS, we hope that this trend can continue, and look forward to receiving further evidence on this for our next review. However, as we said earlier in chapter 1, we would also be interested to see how the number of applications per university place has varied in recent years, given the expansion in the number of medical school places, and would ask the Health Departments for these data for our next review.*
- 6.12 *The BMA has again provided evidence from its Cohort study, outlining reasons why doctors have left medicine. We would ask the Departments to take note of this evidence when developing and putting in place its policies on recruitment and retention, and to consider their impact on morale. Looking at the evidence from the Cohort study, the point made in last year's Report probably bears repeating, of the need to make suitable provision for flexible working arrangements, particularly for a profession in which female staff are now a significant proportion of the overall training grade population.*

Junior doctors' contract

- 6.13 The **Department of Health** said that the new contract was now fully established and that it had been successful in improving the working lives of junior doctors. It said that the use of banding supplements had acted as a financial incentive to encourage NHS Trusts to reduce hours and develop less intensive shift patterns, while at the same time rewarding junior doctors for the hard work and the dedication they showed. Monitoring of compliance with the New Deal carried out in March 2003 revealed that: 79 per cent of all juniors were fully compliant; 89 per cent of all juniors worked less than 56 hours per week; and 26 per cent of Trusts reported all junior doctors were in compliant posts.

- 6.14 The Department said that establishing improvements to working patterns had proved difficult in places, partly as a result of a lack of recognition by some junior doctors of their contractual obligation to monitor their working patterns and to work with their employers to improve compliance. It said that evidence from the monitoring rounds continued to suggest that a significant number of trainees had failed to co-operate with their employers in monitoring working arrangements. It said that this was being addressed locally and the outcome of the September 2003 monitoring was awaited, by which time it said the contractual hours of all posts should have attained compliance. It said that it was discussing with the BMA ways to improve the understanding of juniors as to their responsibilities. Although the contract provided the usual disciplinary processes to enforce the contractual aspect of monitoring, it said that the rotational nature of many posts, involving moves between employers, made it difficult for employers to take appropriate follow-up measures before trainees moved to a post with another employer.
- 6.15 The **SEHD** said there had been significant progress in achieving compliance with the New Deal and a recent survey predicted compliance of 83 per cent at August 2003. It said it had been in discussions with the BMA and NHSScotland to agree a national approach to managing non-compliant rotas for SHOs and SpRs. It said that the Implementation Support Group was continuing to provide advice and guidance on producing compliant rotas, and was considering future approaches to the New Deal contract and the impact of the European Working Time Directive (EWTd).
- 6.16 The **BMA** said that the last phase of the new junior doctors' contract occurred in December 2002, when the final new banding rates came into effect. It said the new contract had been a largely positive development, evidenced by the number of junior doctors moving into New Deal compliant pay bands since the contract was introduced. It welcomed the significantly lower overall rate of New Deal non-compliance of 21 per cent, down from 32 per cent in March 2002. It said that the punitive Band 3 pay rates, together with the incorporation of New Deal hours limits and rest requirements into HO contracts from August 2001, and SHO and SpR contracts from August 2003, had acted as an incentive to employers to reduce hours. It said that HO compliance increased from 44 per cent in March 2001 to 95.3 per cent in March 2003. It hoped that SHO and SpR compliance would follow a similar pattern, but said that it was unlikely as non-compliance was more problematic due to the number of junior doctors involved, with 88 per cent of junior doctors in those grades. It also said that an upward drift of responsibilities to the SHO and SpR grades had aided HO compliance. The BMA also said that it was a major concern that at March 2003, only 85 Trusts (30 per cent of the total) had full New Deal compliance. It said this was unacceptable given that New Deal limits should have been fully implemented seven years ago. It also remained concerned that some junior doctors were facing inappropriate coercion to under report their hours of work in the assessment of banding allocations, and in some cases were asked to sign waivers. Its Cohort study reported that the problem of junior doctors working long hours persisted with over half of SHOs and SpRs in the cohort typically working more than the 56 hour limit imposed by the New Deal, and only three-quarters regarding monitoring exercises as a true reflection of the actual hours worked. It said that many doctors reported that they would welcome a more robust, less labour intensive and more confidential monitoring system. The BMA said it had launched an information campaign to ensure that junior doctors were informed of the correct process with regards to hours monitoring for banding allocation.
- 6.17 In supplementary written evidence, the BMA said that it was inappropriate for the Department to lay the blame for failures in the monitoring system solely at the feet of junior doctors and asked for it to be noted that there were failures on both sides, and for the Department's cooperation in exploring ways to improve the monitoring process.

Comment

- 6.18 *We are pleased to note that more junior doctors are now working in New Deal compliant posts, as we consider the objective of the Deal – to improve the working conditions of doctors by reducing their hours of work – to be a just one. We note here the BMA's comments that there have been failures on both sides with the monitoring system, and would urge the parties to work together as an effective partnership to ensure they achieve full compliance with the New Deal. We will await further evidence on progress in the next round.*

European Working Time Directive

- 6.19 The **Department of Health** said that it was working with the NHS and the profession to develop new ways of working to support compliance with the EWTD and improve patient care. A Memorandum of Understanding set out an agreed approach for improving patient care by increasing numbers of doctors and providing improved medical training, taking into account the implications of extending the EWTD to doctors in training from August 2004. An Expert Group had also been set up to unblock barriers to EWTD implementation, which brought together in one forum the various cross cutting policies that would link closely with EWTD compliance. It said that an Implementation Group had been set up to advise on frontline delivery of EWTD compliance and ensure that it was mainstreamed into strategic planning. It said that Strategic Health Authorities (SHAs) were responsible for managing the performance of NHS Trusts in meeting EWTD requirements, and had been allocated an additional £12 million in 2003-04 to support implementation. It said that NHS Trusts had to prepare robust plans to deliver EWTD compliance, and that plans were due to be signed off no later than 31 December 2003. The plans would be informed by 20 pilot sites testing ways of using staff differently in order to solve EWTD compliance, and by the 'Hospital at Night' initiative, focusing specifically on out-of-hours provision of acute services, which was about to be piloted in four sites. It said it was funding all the pilots at an overall cost of about £7 million this year. The Department said that it envisaged that additional SpR posts might form part of Trusts' plans, alongside consideration of cross-cover arrangements, possible contribution from other staff, and new ways of working. In order to ensure that controls on NTN did not stand in the way of EWTD compliance, it said that it was targeting the additional 1,500 opportunities for locally funded SpR posts towards Trusts that needed them. Additional NTNs would be released on the completion of plans. It also said that the Modernisation Agency was disseminating learning from the pilots and other good practice across the Health Service.
- 6.20 The Department said that a recent ruling (Jaeger) in the European Court of Justice concerning the EWTD confirmed that time spent by doctors resident in hospital doing on-call duties was to be classed as working time for the purposes of the EWTD. It said that the ruling clarified an earlier ruling in the SIMAP case, and also tightened the rules around compensatory rest. The Department said that it was studying the judgement. It said it would have an impact on the NHS, but that the guidance to the service earlier this year had advised Trusts to be SIMAP compliant by August 2004, and so Trusts should already be gearing up for its implementation.
- 6.21 The **National Assembly for Wales** said the EWTD was not a matter that could be dealt with in isolation, and that it had to be considered alongside other factors such as the developments in modernisation, *Agenda for Change*, the consultant contract and the financial resources available. It said that it had asked Trusts to carry out further work to identify ways of delivering services more effectively than at present, which could be offset against the costs of changing the current staff mix required to ensure EWTD compliance.

- 6.22 The **SEHD** said that achieving compliance with the EWTD presented a significant challenge. It said it had issued a framework as a tool for employers and staff for assessing implementation of the EWTD. It said it had been engaging with NHS Boards and Trusts to ensure integrated service planning and a whole systems approach that positioned the EWTD and the New Deal within a wider change programme for NHSScotland. It said it was working with key stakeholders on proposals to set standards for educational quality in EWTD compliant training posts, and on a framework to support NHS action planning for EWTD compliance.
- 6.23 The **BMA** said it was crucial that guidance was produced and propagated to Trusts in time for them to plan towards the implementation of the EWTD for junior doctors in August 2004. Without the guidance, it said that it feared that Trusts would construct hurried and ill-considered working patterns for junior doctors. It was concerned that 50 per cent of current New Deal posts that were non-compliant failed on hours limits, which meant that those junior doctors were working over 56 hours of actual work a week and/or over 72 hours of duty a week. It said that following the European Court's recent rulings, for the purposes of the EWTD, all resident hours for doctors in training were defined as work, and that this definition differed from the New Deal on junior doctors' hours where for the purposes of the 56 hour rule, only those hours spent actually working were defined as work. The BMA said that without further incentive through the pay banding system, the implementation of the EWTD would follow the same pathway the implementation of the Directive took for consultants: the BMA estimated that currently only ten per cent of consultants were working within the EWTD.
- 6.24 The **NHS Confederation** said that the key issue for junior doctors remained the EWTD. It said the deadline of 1 August 2004 for achieving compliance was now close, and all NHS organisations were aware of the pressure this was placing on them. It said that there was now considerable work at national and local level to achieve compliance and it believed that the EWTD might provide an opportunity for Trusts to examine the way services were provided and re-order working arrangements in a way that improved services for patients and the quality of working lives of doctors. It said that re-arranging junior doctors' rotas would be part of a solution, along with skill mix, medical cross-cover, service reconfiguration, developing new roles and training.

Comment

- 6.25 *We have already commented on the importance of junior doctors becoming New Deal compliant. The Working Time Directive will largely supercede the New Deal in respect of Band 3 posts, as Band 3 will become not only New Deal non-compliant, but from August 2004, potentially illegal under the Working Time Directive. We comment later in this chapter about Band 3 multipliers. The parties have both commented on the recent SiMAP and Jaeger judgements in the European Court of Justice, and these judgements will certainly have implications for the working lives of junior doctors, with the Health Departments looking at alternative ways of working in order to provide cover. We would ask that the Departments bear in mind the effect on junior doctors' morale of any such alternative arrangements that they might put in place to become Working Time Directive compliant.*

Banding multipliers

6.26 *The following table shows the current levels of the non-pensionable multipliers that apply to the basic pay of whole-time doctors and dentists in training grades (and flexible trainees working 40 hours or more a week or in New Deal non-compliant posts):*

Band	1C	1B	1A	2B	2A	3
Multiplier	1.20	1.40	1.50	1.50	1.80	2.00

6.27 The **BMA** reminded us that the levels of the December 2004 banding multipliers would be our responsibility. It said that under the banding system as it currently stood, doctors working under a Band 2B rota received the same banding multiplier (1.5) as those working under a Band 1A rota. It said that a doctor working a Band 2B rota worked between 48 and 56 hours a week, whereas a doctor on a 1A rota worked less than 48 hours a week, a difference of eight hours. Although the intention was that Band 1A should reflect a greater number of antisocial hours despite the fewer total hours, the BMA said that it could be the case that a doctor working 56 hours a week on a full or partial shift involving one weekend in four would receive the same multiplier as a doctor working 48 hours a week (or less) and also working one weekend in four. The BMA said that this discrepancy in the existing banding multipliers was unfair and that an increase to the Band 2B multiplier was warranted to reflect the additional hours that doctors in that Band must work. It therefore asked us to recommend an increase to the Band 2B multiplier.

6.28 The BMA said that under the current banding system, all Band 2 and 3 posts would be unworkable under the EWTD when fully implemented in 2009, as they involved more than 48 hours of work each week. Currently 82 per cent of junior doctors were in Band 2 or 3 posts, and by 2009 all those doctors would be required to be working in Band 1 rotas (less than 48 hours per week) and the BMA said that many of them would be working in Band 1 posts from next year. It said that the existing multipliers meant that those doctors would face a significant decrease in pay in both actual and relative terms. At the current level of multipliers, it said an SpR on the mid-point of the salary scale moving from Band 2A to Band 1A would be almost £10,000 per year worse off, a pay cut of over 16 per cent. It said that although pay protection applied in the short term for doctors in post and for future posts on a rotation, ultimately, unless changes were made to basic salary and to the Band 1 multipliers, the move to Band 1 for all doctors would significantly reduce the average salary for a junior doctor. The BMA said that we had stated in previous reports that the large pay increases in junior doctors' salaries following the implementation of the banding system were a significant factor in determining the pay award and the justification for a relatively low increase to the basic salary. It said that the effects of the introduction of the EWTD on junior doctors' salaries would negate any previous increases. It suggested that increasing the Band 1 multipliers would go some way towards reducing the effect and would also promote a positive attitude amongst junior doctors who would be moving to Band 1 posts, by avoiding dramatic decreases in their take home pay. The BMA therefore asked us to recommend an increase to the Band 1 multipliers.

6.29 The **Health Departments** confirmed that the banding multipliers were now free-standing, reviewable annually by us. They said that between 2002-03 and 2003-04, the three per cent of trainees in Band 1B had received an increase in pay of 11.2 per cent; the 23 per cent of junior doctors that were in Bands 1A or 2B had received increases in pay of 9.1 per cent; the 48 per cent of junior doctors in Band 2A had received an increase of 16.1 per cent; and the 21 per cent of trainees in Band 3 had received an increase in pay of 21.5 per cent. Five per cent had received an increase in pay of just 3.2 per cent, but this included those whose banding multipliers were already at maximum.

- 6.30 They said that the multipliers for compliant bands were now set at a level that fully reflected the relativities that they and the BMA had agreed in 2000 to reflect different patterns of work intensity and out-of-hours commitment. They said they remained of the view that those relativities were fair and that they provided an appropriate financial incentive for Trusts to manage the workload of doctors in training. The Departments said that they believed that the focus for a fresh consideration of pay for doctors in training should be the impact of *Modernising Medical Careers*. They said this would enable the parties to take a fresh view on the appropriate levels of pay for a pathway from trainee to trained doctor in an environment where hours had been significantly reduced. They said that where hours reduced, the presumption must be that higher levels of pay were no longer justified. To do otherwise would undermine the principle of matching levels of pay to relative work intensity and out-of-hours commitments and would also prevent resources being re-deployed to secure, in other ways, the extra capacity that would be needed as hours were reduced for doctors in training.
- 6.31 The Departments said that a punitive rate for non-compliant posts had been helpful in the early stages of the contract in encouraging Trusts to reduce hours, but once the early benefits were gained, the higher rates had become an attraction for juniors rather than a disincentive for Trusts. They said that there was some evidence that Band 3 payments might have had the unforeseen consequence of making doctors reluctant to take up a consultant contract. They said that increasing the multipliers would risk providing a perverse incentive for doctors to maintain non-compliant working, and that they were aware of some falsification of returns and of disciplinary action that had been taken. If the non-compliant multipliers were further increased, they said there would be a very real risk that it would merely create a greater financial incentive for juniors to maintain non-compliant working practices. They said that using pay to penalise an employer was, in any case, no longer necessary as there were now additional contractual and legislative penalties. Pressure on employers to comply with the New Deal was increasing, and they said that those employing doctors in non-compliant posts faced the possibility of an industrial tribunal. In addition, from August 2004 when the Working Time Regulations would apply to doctors in training, employers would be accountable to the Health and Safety Executive for breaches of the hours limits. They said that they expected Band 3 payments to wither over the next year.
- 6.32 The Health Departments said they opposed any suggestion that the multiplier for non-compliant posts should be raised. They said that the system needed a review to prevent further distortion of pay differentials between doctors in training and other medical grades. They said that possible approaches would be to convert the multipliers into fixed supplements that did not automatically increase in line with increases in basic pay, or to remove Band 3 and reinvest the money in other ways. Whilst they said they would support an early move in such a direction, they would also be prepared to support maintaining the current value of the multipliers in percentage terms for this year with a view to reviewing the system as part of a fresh consideration of pay for doctors in training to take account of the impact of *Modernising Medical Careers*. They asked for our support for this latter approach.
- 6.33 In supplementary evidence, the Health Departments said that the suggestion that Band 1 salaries should be increased simply because more doctors would fall within that Band in future flew in the face of the basic principle of fair payment for work done. They said that either Band 1 pay was set now at an appropriate level for those currently in Band 1, or it was not. The fact that more doctors might be in Band 1 in the future was in the most part irrelevant – the work that would be required of them would be the same as doctors already in Band 1, and there appeared to be no suggestion that such work was inadequately remunerated at present. They said that it was worth noting that the

banding system was recognised as a very broad tool, with a wide range of working arrangements encompassed in each band. In a single band, the variation in average working hours of doctors carrying out work of similar intensity on the same salary could be as much as a full day's work (eight hours) a week. To attempt to balance the difference between the extremities of, say, Band 1A and Band 2B (without seeking to address more serious inequalities in the arrangements at the same time) would, the Departments said, be to chip at a part of the problem.

- 6.34 They said that between the two monitoring rounds in March and September 2003, the relative proportions of trainees in Bands 1 and 2 remained constant, whilst overall more posts became compliant with the New Deal. They said that they had no reason to suppose that the proportion of doctors in Band 1 would increase significantly in the next twelve months, particularly given the service constraints imposed by the Working Time Regulations. They said they expected the situation over the next year to remain relatively static in banding terms. The evidence did not, in their view, provide any basis for increasing Band 1 payments. They said they would prefer not to attempt to tinker with small aspects of the banding system at this stage, but to begin a fundamental review of the whole system.
- 6.35 The **NHS Confederation** said that it was very important that we did nothing to make the task of compliance more difficult, and it urged us not to increase the multiplier for Band 3 payments. It said that the Banding system had worked in a perverse manner: whilst the high costs of Band 3 payments for Trusts were a spur for action to reduce working hours, they were equally a disincentive for doctors themselves to reduce hours of work, or to cooperate in monitoring exercises.
- 6.36 The **SEHD** endorsed the Department of Health's proposal for a review of the operation of the banding multipliers for non-compliant junior doctor posts.
- 6.37 In supplementary evidence, the **BMA** said that it had been unable to ascertain how the Department of Health had reached the figure of pay increases for junior doctors of up to 21.5 per cent over the past year and would welcome an explanation of the methods used. It acknowledged that the December 2002 increase in the banding multipliers would have led to large salary increases for some doctors, but the requirement for all junior doctors to be in compliant posts from August 2003 and the imminent implementation of the EWTD meant many Trusts were changing rotas now, and hence many existing junior doctors had actually had their pay cut. For some this had been by up to 14 per cent. The gradual move through the pay bands which it expected was being replaced by a headlong rush to get as many junior doctors as possible into Band 1 by next August, with the consequent sudden severe drop in pay for many.
- 6.38 However, the BMA said it agreed that the multiplier for non-compliant posts should not be increased, but that whilst junior doctors were still working in Band 3 posts or unstable compliant posts, Band 3 should continue at its current level and continue to apply to all those junior doctors who were in non-compliant posts going forward. It said that the number of doctors in Band 3 was decreasing and the trend was expected to continue, and that the cash burden of maintaining Band 3 would fall over time. Reducing the multiplier would send the wrong message to the service.
- 6.39 The BMA said that the Department seemed reluctant to discuss the levels of the compliant bands. It said that it had been agreed by all parties when the banding levels were set initially that they would be reviewable annually by us, and that considering the changes in circumstances that had transpired in the intervening time, that provision was vital and should be used. It said that the banding multipliers were payment for the out-

of-hours component of doctors' work and that should not be overlooked. In almost every other profession, overtime was paid as a percentage supplement to basic pay, usually double, and it said that the suggestion by the Department that the multipliers could be converted into fixed supplements that did not increase in line with basic pay went against the recommendations in *Agenda for Change*. The BMA said it would oppose any move to fix the supplements for out-of-hours work.

- 6.40 In further supplementary evidence, the BMA said that it did not at present see any need for a review of the junior doctors' contract, whether for the purposes of *Modernising Medical Careers*, or any other. It said that the present framework could accommodate *Modernising Medical Careers*.

Comment

- 6.41 *The parties have confirmed that responsibility for setting the levels of the pay banding multipliers now rests with us. The BMA has asked us to recommend an increase to the Band 2B multiplier to remove what it sees as an anomalous relationship with the Band 1A multiplier. We note that this proposal was not accompanied by any proposal to reduce the level of any other multiplier, or any consideration of the appropriate relativities with the other multipliers. The point made by the Department that the banding system was recognised as a very broad tool, with a wide range of working arrangements encompassed in each band, seems a fair one. We consider that the current levels of the banding multipliers, as negotiated between the parties, are now set at a rate that fully reflects the out-of-hours commitment and intensity of posts. In the absence of any detailed evidence as to why the current levels might be inappropriate, we **recommend** (recommendation 15) that the percentage values of the current multipliers be rolled forward for another year. The detail of our recommendation is at Appendix A.*
- 6.42 *The Department has suggested that it might wish in the future to turn the value of the multipliers into fixed supplements. This is, of course, a matter for negotiation between the parties. However, under the current agreement, such a proposal would decrease the value of the multipliers, and is not what the parties appear to have negotiated. We would not support such a move.*
- 6.43 *The BMA has also asked us to increase the level of the Band 1 multipliers to help avoid dramatic decreases in the take-home pay of junior doctors. We would repeat here that we believe the current levels of the pay banding multipliers fully reflect the out-of-hours commitment and intensity of posts. When negotiating the banding multipliers, the parties were aware that juniors' earnings would fall as hours fell. We do not therefore consider it appropriate to recommend an increase to the Band 1 multipliers on that basis.*
- 6.44 *We would however make the point here that as junior doctors move down through the bands, and the effect of the banding multipliers on total earnings lessens, then we will need to consider more closely the level of basic pay. We do not intend to lose sight of the fact that the levels of basic pay must be kept under review as the effect on earnings of the pay banding multipliers begins to decrease.*
- 6.45 *The parties have both asked us to roll forward the current value of the New Deal non-compliant Band 3 multiplier. We have done this in our earlier recommendation. However, we have already noted that from August 2004, Band 3 posts would be potentially illegal under the Working Time Directive and would run the risk of action being brought by individuals under Health and Safety legislation. We would expect employers to make every effort to eliminate all Band 3 posts from August 2004, and it seems clear from the Department's evidence that a great deal of effort is being directed towards this. We would ask the parties to provide us with evidence for our next round on any use of Band 3 posts from August 2004.*

6.46 *The Department has asked for our support for a review of juniors' pay to take account of the impact of Modernising Medical Careers. This is, again, a matter for negotiation between the parties. However, on the face of it, there seems no reason why the current pay structure could not accommodate a reduction in the number of years spent in training, as envisaged under Modernising Medical Careers. We would ask the parties to report to us in the next round on any discussions about pay in the context of Modernising Medical Careers.*

Career bottlenecks

6.47 The BMA said that the bottleneck at entry to the SpR grade was already a major hurdle for doctors. It said it was still highly competitive and the failure rate was much higher than that of any postgraduate examination. The BMA noted that we had asked for further information on the national distribution of SHO and SpR grades. It said that an examination of its Cohort study of 1995 graduates showed that 58 per cent remained in the SHO grade for five years or more. It also said that in a study carried out for the Department of Health by the National Institute of Careers Education and Counselling, the results had highlighted that many doctors were spending a long time as SHOs, with 14 per cent of UK doctors and 27 per cent of overseas doctors still being SHOs five years after registration. It also said that the study noted that the high level of competition for NTN means that many specialties were now making it a requirement for applicants to have completed a research degree to qualify for a number. It said that this delayed career progression by up to three years. The BMA said this was supported by its ongoing Cohort study of 500 doctors: of those respondents that were currently undertaking a postgraduate degree or working as research fellows, 43 per cent stated their reason for doing so as being to secure an NTN necessary to get an SpR post. Those doctors undertaking research as part of their clinical post were also questioned about their reasons, and more than half said they were doing so as a means of career progression or of securing an SpR post.

6.48 The BMA said that a doctor who was now at the top of the SHO scale, point six, would transfer to point five on the SpR pay scale. It said that with SpR training schemes of five to six years, it implied that such a doctor would come to the top SpR pay point eight and remain on that point for one to two years, depending on the length of the SpR training programme. It also said that a surgeon who moved from SHO point six to SpR point five would remain on point eight of the SpR pay scale for three years, since surgeons had a minimum six year SpR training programme. It said that the logical progression from an extra SHO point, was to create two additional points on the SpR pay scale. It said this would allow salary progression for those SpRs stuck at the top of their pay scale. The BMA said that its data from Glasgow showed that a high proportion of SpRs were reaching the top point of the current salary scales, and this, together with the points it had made on career bottlenecks, set out a clear demand for additional points to be added to the SpR scale. In addition, it said that the likely increase of flexible and part-time trainees would result in an increase in the number of doctors spending more years in the SHO and SpR grades, and consequently reaching the maximum point of the pay scales. The BMA therefore asked us to recommend two extra incremental points to the SpR grade.

6.49 The **Department of Health** said that as part of the implementation of *Modernising Medical Careers*, it aimed to bring numbers in training into balance with numbers in career grade posts so that doctors were able to progress smoothly. Enough higher training posts would be provided for all suitably competent doctors to progress. In future, it said that they would expect numbers at SHO level to be driven by the number of doctors entering the training system. The Department said there was currently no shortage of applicants for SHO posts.

- 6.50 As *Modernising Medical Careers* was implemented, the Department said that SpR numbers would be increasingly driven by inputs into the training system. Its current approach to SpR increases aimed to free up the training system and allow as many doctors as possible to progress to higher specialist training. The *NHS Plan* had made a commitment to substantially increase SpR numbers, stating that by 2004 there would be 1,000 more SpRs than in 1999. The Department said that central funding had been made available to support that, and the final tranche of 400 additional training opportunities had been distributed in 2003-04. This had particularly benefited clinical radiology (78 posts), histopathology (75 posts) and psychiatry specialties (60 posts). It said that the latest census data showed that by September 2002, the Department had already exceeded the *NHS Plan* target, increasing SpR numbers by 1,090 since September 1999.
- 6.51 The Department said that it was moving people through the training system more quickly, to increase the supply of applicants for consultant posts in future years. It said that as well as distributing central funding in 2003-04, scope had been given to Trusts to create up to 1,500 additional SpR opportunities. It said it was also tackling training bottlenecks to allow more SHOs to progress to SpR level, giving Trusts the opportunity to convert up to 1,300 existing SHO posts into SpR posts: up to 700 in surgery, and up to 600 in other specialties. It said that this approach of allowing Trusts to fund additional SpR posts was piloted in 2002-03, when around 500 bids for additional posts were agreed. Implementation was still continuing, but as at June 2003, an appointment had been made for 315 of the posts, and a further 95 were at advertisement or interview stage. The Department said that this indicated that Trusts were keen to make use of the strategy.
- 6.52 The Department said that the measures to increase SpR posts, and to allow Trusts to convert SHO to SpR posts, would allow more doctors to progress to higher specialist training. The Department said that as implementation of *Modernising Medical Careers* progressed, it anticipated that the levels at which SpR numbers were set in each specialty would increasingly be devolved to the level of SHAs. It said it would continue to maintain a national overview, but would expect planning for the larger specialties to be carried out locally. The Department said it was also taking action to encourage and support SpRs in making the transition to the consultant role. The Consultant Monitoring System, introduced in June 2003, allowed Trusts to record details of all planned posts by specialty. Data on consultant posts were also used for international recruitment matching schemes, and a pilot was underway to give SpRs access to the information.
- 6.53 Commenting on the proposals outlined in *Modernising Medical Careers*, the **BMA** said that there would be more competition for the most popular posts. It said there were usually 20 applicants for each SpR post in paediatric cardiology. Whilst it welcomed the announcement of 1,000 extra SpR posts, it was concerned that they were to be concentrated in Trusts with the greatest difficulty in tackling the problems of the EWTD. The BMA said the extra SpR posts should be allocated according to training needs, not the NHS service need. It also felt that for the additional NTN to be administered effectively, they needed to be funded centrally and not via local mechanisms as had been largely proposed. The BMA said that very little of the hoped for money for the locally funded NTNs had been forthcoming.
- 6.54 The BMA said that the *Modernising Medical Careers* scheme raised a number of issues surrounding the pay of doctors in the early years. It said that the proposed new system replaced the current HO/SHO/SpR pathway with a two-year foundation programme followed by specialist training. It was concerned that under the current pay structure, those doctors involved in the pilots, who would be moving into the second year of the

foundation programme in August 2004, might be kept on the HO salary scale. The BMA felt it was essential that the salary progression of such doctors was not disrupted by their involvement in the scheme. It therefore asked us to clarify that the doctors involved in the pilots would progress onto the SHO scale in the same manner as their colleagues in non-pilot sites.

- 6.55 In supplementary evidence, the **Department of Health** said that rather than be awarded an increment on the HO scale, following full registration, a trainee entering the second year of the pilot foundation course should move onto the minimum of the SHO scale, retaining parity of pay with peers undertaking the conventional training route. The Department said that it accepted this was a sensible approach and was already implementing this in the pilot sites. Moves to reflect this in Terms and Conditions of Service would be considered in due course, as part of the broader implementation of *Modernising Medical Careers*.
- 6.56 In supplementary evidence, the **BMA** said that it had a number of serious concerns surrounding the foundation programme pilots, particularly the lack of clarity on the contractual arrangements for doctors working in those posts. It said it failed to see how a consultant could be trained effectively in only four years. It also highlighted some of its concerns relating to the Department's plans to bring the numbers of doctors in training into balance with the number in career grade posts
- 6.57 In supplementary evidence, the **Department of Health** said that the estimated distribution of SHOs and SpRs by spine point was as follows:

	0	1	2	3	4	5	6	7	8
SpRs	440	530	1090	1500	2190	2140	1770	1530	2060
%	3	4	8	11	17	16	13	12	16
SHOs	5430	3540	2920	1710	1110	1040	1160		
%	32	21	17	10	7	6	7		

- 6.58 In supplementary evidence, the **BMA** said that it questioned the Department's proposals to convert 1,300 SHO posts into SpR posts, particularly in the light of a recent letter from Professor Field, Chairman of the *Modernising Medical Careers* delivery board, which called for an increase in the number of SHO posts. It said that a reduction in the number of SHO posts would inevitably lead to a shortage of SHO posts. The BMA said that the Department was also proposing that the additional 1,500 SpR posts were locally funded. It said it had concerns over this. Firstly, it said that only 315 of the released, locally funded NTN had been taken up, indicating that Trusts were reluctant to fund NTNs themselves, and secondly, it wanted assurances that additional posts were allocated on the basis of the availability of high quality training opportunities and not because of service need.

Comment

- 6.59 *We are pleased to note that the Department has agreed that those junior doctors and dentists taking part in the pilots for Modernising Medical Careers will retain parity of pay with their peers undertaking the normal training route.*

- 6.60 *Last year, we asked the parties for further evidence on the national distribution of SHOs and SpRs by incremental point. The BMA has returned to evidence from Glasgow. We would repeat the point made in our last report, that Glasgow may or may not be typical of the national situation, but that by itself the evidence on one city does not warrant action. However, the Department has provided estimates of the national distribution, for which we thank it. The data shows that relatively few SpRs are on the bottom points of the SpR payscale. This is likely to be due to the length of time spent in the SHO grade, and supports the suggestion that there has been a problem in obtaining NTN's to enable progression to the SpR grade. SHOs have therefore transferred to the SpR payscale at a higher spine point. This appears to have had the knock-on effect of the SpR payscale not having enough headroom to support the length of training, as demonstrated in the data by the bunching at the top of the SpR payscale.*
- 6.61 *We would note here that incremental progression for the training grades, subject to satisfactory performance, appears to have been the principle supporting the SHO and SpR payscales to date. We are satisfied that the evidence demonstrates that some SpRs are becoming stuck at the top of their payscale, and feel that the case has been made for the awarding of one extra incremental point to the SpR grade, subject to satisfactory performance. The detail of our **recommendation** (recommendation 16) is at Appendix A. In recommending the additional point, we would ask the Department to take note of the potentially demoralising effect of the drop of earnings for SpRs on promotion to consultant, and urge it to ensure that its plans to remove career bottlenecks are taken forward without delay. We note here that as career progression problems are resolved through action to tackle training bottlenecks, as suggested by the Department in its evidence, then the need to use the additional incremental point should decrease. We would therefore expect the cluster at the top of the SpR payscale to diminish as the impact of the Department's plans begins to filter through. We would ask the parties to continue to monitor the national distribution of SHOs and SpRs by spine point, and to let us have further evidence for our next review.*

Regional and local variations and London weighting

- 6.62 In supplementary evidence, the BMA said that it was pleased that the Department had noted that various regions/cities faced above average prices and the BMA said it believed that it was appropriate that doctors working in more expensive areas should be compensated accordingly. It said that recruitment and retention premiums could be effective, but they must not detract from the need to improve standards in Trusts where recruitment problems were due to poor living and working conditions, and it said that any pay differentials to encourage recruitment must take the form of a separately identified variable supplement to the existing pay system, and must not in anyway affect basic pay rates in other regions or future pay increases.
- 6.63 The BMA said that the Department had not recommended any change to the cash value of London weighting. It said that the basis for that recommendation had been evidence from the vacancy rates for consultants that suggested that recruitment was easier within London than elsewhere. The BMA said that figures for doctors in the training grades had not been made available, but it had been made aware of recruitment difficulties in the North Thames region, particularly in anaesthesia and paediatrics. It said that the purpose of London weighting was not to encourage recruitment and retention, but to reflect the higher cost of living and to ensure that those who worked in the city were not disadvantaged and had the same spending power as others across the United Kingdom. It said that the London Weighting Index calculated by the Labour Research Department sought to calculate the additional costs of housing and travelling to work in London to determine the appropriate level of London weighting, and it had recommended a minimum of £3,287 a year for workers in inner London.

- 6.64 It said that London remained one of the most expensive cities in the world and was the most expensive city in the European Union, yet the cash value of London weighting for junior doctors had already fallen behind that of other staff groups within the NHS, and the disparity would become even greater following the implementation of the *Agenda for Change* agreement, when a maximum London weighting of £5,161 would be introduced. It said that the Department of Health had not extended the recommendations for London weighting in *Agenda for Change* to doctors, as Trusts did not have to compete in the external labour market to attract staff, and because the Department knew that junior doctors had no other choice of employer and were limited in the career options available to them. It said that junior doctors received the lowest London weighting of all groups in the public sector.

Comment

- 6.65 *We discussed London weighting for all our remit groups in chapter 1 and set out there our recommendation for 2004-05. We would just repeat the call here for the Department of Health to provide us with evidence covering all our remit groups, including doctors and dentists in training, to enable us to consider this issue more fully in the next round.*

Flexible trainees

- 6.66 The **BMA** said that the short-term funding agreement of £14 million settled in 2002 had offered some respite from the flexible training funding problems. However, it said that the funding would end in April 2004, and it remained seriously concerned about what would happen in the following financial year. It said it had already received reports of the withdrawal of flexible training posts due to funding problems. It said it was essential for the problem to be dealt with on a long-term basis taking into account the growing numbers of trainees wishing to work less than full time. It said it was currently conducting research on flexible training, looking at access to the scheme, providing a critical appraisal of the scheme, identifying problems and barriers and good practice where it existed. The BMA asked for our support to find a long-term solution to the problem of flexible training. It said that the scheme in its current form would be unlikely to be able to support an increase in the level of demand for flexible training, and suggested that the scheme should form one part of a menu of flexible working options available to junior doctors, and that the scheme should be based on a combination of 'off the peg' part-time posts with 'custom made' part-time posts. It also suggested that flexible training posts should be funded centrally.
- 6.67 In supplementary evidence, the BMA said it welcomed the recent suggestion from the Department that the number of flexible trainee posts be increased, and it was keen to work with the Department to find new ways of achieving that goal. It said that it was vital that new funding arrangements separately identified and ring fenced funding for flexible trainee posts. It said that significantly increasing the numbers in flexible training would require much more funding than had been available to date, and that it continued to believe the funding should be provided centrally.
- 6.68 The **NHS Confederation** said that it recognised the importance of flexible training and of flexible careers for doctors. However, it said that the current financial arrangements acted as a major disincentive to Trusts to promote flexible training, and that from a Trust perspective, it was hard to justify the level of payment to flexible trainees. The Confederation said it recognised the sensitivities involved, but believed that the arrangements should be reviewed for future staff so that a scheme could be introduced which would actually encourage employers to promote flexible training, rather than avoid it.

- 6.69 The **Department of Health** said that flexible trainees continued to experience difficulties in obtaining posts, and that this served to show up problems experienced by employers in changing working practices to accommodate flexible trainees. It said it remained convinced that the contract was flawed in respect of flexible trainees, with employers still resisting the concept of paying a part-time trainee a salary based on a full-time salary, plus a supplement. The Department believed that this approach had significantly damaged the employment opportunities of junior doctors, and that a contract that could be seen by employers to be founded on a pro-rata basis would ease the problem greatly. The Department said it was aware that an increasing number of trainees wished to train on a part-time basis and fully supported the principle of flexible training and flexible career initiatives that promoted an improved work-life balance. This must however, it said, be also viewed from the perspective of the employer, who currently saw a full-time trainee reducing their hours as not only a reduction in available service capacity, but as an increased cost when it came to replacing the capacity lost. It said that in the implementation phase of the contract, banding multipliers for flexible trainees were introduced in full from the outset, whilst those for full-timers were phased in over two years. The Department said that this had had the immediate effect of making the cost of employment of flexible trainees more expensive for employers than full-time trainees, both in terms of actual cost per trainee and of service contribution. It said that whilst the imbalance had reduced now that the banding multipliers for full-time trainees were fully in place, some employers remained reluctant to take flexible trainees.
- 6.70 The Department said that whilst it accepted that the payment of salary costs over and above contracted hours was rightly the responsibility of employing Trusts, to assist employers in meeting additional costs while the full-time banding multipliers reached their target values, it had made an additional £7 million available to the service in both 2002-03 and 2003-04. This did not address the fundamental flaw in the contract whereby flexible trainees were not paid pro rata to their full-time counterparts. The Department said that as long as the situation persisted, some Trusts would continue to be reluctant to employ flexible trainees, and it said it would welcome our support for reviewing that element of the contract.
- 6.71 The **SEHD** said that a working group had identified improvements to assist in the employment of less than full-time doctors in training. It said that it had provided an additional £700,000 in 2003-04 to help fund them. It supported the Department's proposal to review the application of the contract for flexible trainees.

Comment

- 6.72 *The parties are agreed on the need for a review of the current contract as it applies to flexible trainees, and we therefore hope that a workable solution can be arrived at between the parties quickly, as we consider that this needs urgent resolution. For our part, we would ask the Health Departments to consider carefully both the need to minimise retention difficulties and their commitment to promoting flexible working arrangements when re-negotiating the application of the contract to flexible trainees. These points would appear to us to be particularly pertinent given the increasing proportion of women in the medical workforce.*

Student debt

- 6.73 The **BMA** said that postgraduate exams and essential courses incurred major financial costs for all doctors that were not similarly reflected in other professions, where it was usual practice for employers to cover the exam and course costs. It said the examination fees of Royal Colleges varied between £600 and over £1,000, and doctors were not

eligible for study leave funding. In addition, doctors were faced with the cost of registration/certification fees, annual college membership fees, and other further course/conference costs. It said that this often left a deficit beyond an individual's study leave funding allocation of over £1,000 per year to be made up by the trainee. The BMA asked us to take these essential costs into consideration when determining the pay award for junior doctors.

- 6.74 The BMA said that the average amount of debt for medical students had risen to £10,966, an increase of 13 per cent on the previous year. Final year students had an average debt of £12,915, with fourth year students having an average debt of £13,642. It said that other graduates typically left with debts of £8,125, almost £5,000 less than medical students. Although applicants from the UK and overseas to medical schools had increased again in 2002, it said the proportion of applications for medicine from the poorest social groups remained low. It said that the prospect of above average debt should be seen as a significant factor, and it felt that the trend would only be exacerbated by the Government proposals to increase the level of tuition fees. It said that in order to fulfil the Government's drive to attract a broad socio-economic mix of students into medical education for a diverse medical workforce in the future, the disparity needed to be addressed. The BMA said that it felt that part of the solution in addressing the issue of debt would be to have an above average pay award for HOs through the removal of the bottom two points of the HO scale. It said this would bring HO pay closer to the SHO scale, and asked us to recommend accordingly.
- 6.75 The **Health Departments** said that when the value of the free accommodation provided in the first year of training was taken into consideration, the position of medical graduates was comparatively better than graduates in other professions. They said that after taking into consideration the longer university course and the consequent potential for higher levels of student debt, the savings on accommodation and travel to work (because most HOs were housed in or close to their base hospital) combined with a salary at the top end of the graduate spectrum still left medicine as an attractive career choice.
- 6.76 In supplementary evidence, the Health Departments said that medical and dental students already benefited from more generous financial support than that available to many others in higher education, in recognition of the length and specialist nature of their training. They said that from August 1998, students became eligible for tuition fee support and NHS bursaries in their fifth and subsequent years of study, or their second and subsequent years in the case of students undertaking the new four-year graduate entry courses. Bursary rates had increased every year since 1998. The **Department of Health** said it would continue to monitor demand for, and take up of, places on medical courses after the introduction of variable fees in 2006-07. It would consider, in consultation with the Department for Education and Skills, measures it saw as necessary to safeguard the supply, retention, diversity or quality of students on health professional training courses, once the full implications of the introduction of variable tuition fees could be assessed.
- 6.77 The Department also said that over half of the employers questioned in the Association of Graduate Recruiters 2003 Survey said they expected graduates' starting salaries to increase in 2004, but only by the cost-of-living, with a third of employers predicting salaries would be frozen at 2003 levels. The Department said that the Survey also showed that the average starting pay for HOs in 2003 was £33,494, with 78 per cent earning £34,533 or more, and this compared well with other professions; only investment banking paid more on graduation.

- 6.78 In supplementary evidence, the **BMA** said that the Department's evidence compared salaries of HOs with other graduates, but the levels compared were not reflective. It said the Department included the banding supplements for out-of-hours work for the salary levels of HOs, yet the salary levels for other professions were the basic salary. Furthermore, the Working Time Directive already applied to the other workers, and hence their salaries related to 48 hours of work and not the 56 or more that were common for many junior doctors. It also said that the comparison salaries did not include the additional benefits that employees in those sectors received, e.g. professional exam fees paid, salary increases on passing exams, bonuses, etc.
- 6.79 The BMA said that a recent study¹ stated that individuals from lower social classes were more likely not to go to university, and that among other reasons, debt aversion deterred entry into higher education.

Comment

- 6.80 *We commented last year that the time to consider whether basic pay for house officers had got seriously out of line with comparators might be when the effect of the pay banding multipliers began to decrease, or if any recruitment or retention problems became apparent. The evidence put forward by the parties does not suggest that this is the case, and our conclusion from last year therefore stands. However, we note that the Department continues to draw comparisons between the earnings of juniors and the basic salaries of other graduates. Whilst we cannot ignore the effect of the banding multipliers, we would stress that it is important that basic pay is set at an appropriate level. We will monitor this carefully for our next round.*
- 6.81 *The BMA is concerned that fear of student debt might be deterring applications to study medicine from the lowest social groups. We note here that the Department intends considering measures to safeguard the supply, retention, diversity and quality of students. We ask that it take this forward, to ensure that medicine continues to attract a diverse socio-economic mix of students. As part of this, we would particularly ask the Department of Health to monitor the demand for, and take up, of places on medical courses after the introduction of variable fees in 2006-07.*

Level of basic pay and the pay award

- 6.82 The **BMA** said it was also concerned that the level of pay for junior doctors was falling further behind that of other professions. It said that only four years after qualification, a lawyer could expect to earn £61,500, and an accountant could expect to earn in excess of £60,000 five years after qualification. Following the implementation of the EWTD, the maximum a junior doctor would be able to earn five years post qualification was £42,173. The BMA also felt that a substantial increase to the basic pay was necessary to alleviate the excessive pay cuts for junior doctors of all grades as they moved to Band 1, partly driven by the implementation of the EWTD. The BMA therefore asked us to recommend an above average increase to the basic pay for junior doctors.
- 6.83 The **Department of Health** referred to the large pay increases since the introduction of the new contract in 2000 and said that it saw no justification for uplifting the pay of junior doctors by more than 2.5 per cent.

¹ *Attitudes to Debt, by Claire Callender et al, Feb 03, Universities UK*

- 6.84 In supplementary evidence, the **BMA** said that the Department's proposal of a 2.5 per cent uplift for junior doctors was in no way acceptable, and was at odds with the Department's desire to encourage entry and re-entry into medicine. It said that the Department claimed that the figure of 2.5 per cent was in line with inflation for the coming year, but it said that the current RPIX stood at 2.7 per cent and had not fallen below 2.5 per cent for over a year. It said that the level of wage/salary inflation, which it considered a more appropriate comparator, was currently 3.6 per cent; and that the Government's inflation target for the economy as a whole in 2004-05 was 2.59 per cent.
- 6.85 The BMA also said that the Department seemed to be advocating the introduction of performance related pay². It said it opposed the introduction of such a system, and said that in medicine, and particularly for doctors in training, such a system was wholly inappropriate. It asked for our assurance that we would not endorse the introduction of performance related pay in the future.
- 6.86 The **NHS Confederation** said that it had considered at some length what award it should propose for junior doctors. It said that it was aware of the Department's recommendation of an award of 2.5 per cent, and it understood the logic of its argument. However, it said that it believed that, on balance, the benefits of such an award would be outweighed by the divisive effect it would have in industrial relations terms, particularly at a time when NHS employers were actively seeking the cooperation of junior doctors to ensure EWTD compliance. Equally it said it did not believe there was any case for junior doctors to receive a greater increase than consultants, as that too would have a damaging divisive effect. The Confederation therefore believed the award for junior doctors should be the same as for consultants, and that it would be sensible for the award to cover two years. It therefore recommended that the general pay award for junior doctors should be 3.225 per cent per annum for 2004-05 and 2005-06, and that we should not recommend any other changes to the pay system.
- 6.87 In supplementary evidence, the **Health Departments** referred to data on total earnings from the New Earnings Survey. They said that the data included those, like junior doctors, who were not considered fully qualified in their chosen profession, for example, junior lawyers. They said that the data suggested doctors compared very favourably with other careers, many of which also had long training periods. For example, veterinarians, like doctors, typically studied a five-year course and their average salary was £32,000. The solicitors and lawyers, judges and coroners' group had an average of £48,000. They also said that the data did not take account of non-pay employment benefits, and that whilst many senior jobs in the private sector might have cars or medical insurance as perks, the NHS pension scheme available to doctors was much more generous than most private schemes, with retirement at 60, six per cent contributions, and based on final salary.
- 6.88 They said that the BMA's evidence of other profession's salaries was potentially misleading, and suggested that a comparison with consultants' earnings might be more appropriate. More important than the wage estimates was, in their view, the total lifetime earnings of different professions, or more specifically, the rates of return for different types of education. They referred to research published in March 2003 in Labour Market Trends by Walker and Zhu that compared returns from different degree subjects. They said that the highest three returns were very similar and were Law, Health and Economics/Business; and that data for women showed a parallel picture. They said that the research suggested that, at a minimum, the returns to medical degrees were equal top with Law and Economics/ Business, even before taking into account the new consultant and GMS contracts. They said that the findings did not provide any basis for justifying above average increases for junior doctors.

² Paragraph 3.8 of the Department of Health's evidence refers, summarised in paragraph 1.34.

Comment

- 6.89 *The BMA has asked for our support in opposing the introduction of performance related pay in the future. We consider that this is a matter for future negotiation between the parties.*
- 6.90 *Our deliberations this year have been made against the background of a continuing reduction in the number of working hours of junior doctors and dentists, which we welcome. We note that the parties have provided contrasting views on the future rate of that reduction, but what is clear is that the reduction will continue. We have already commented in this chapter on our concerns that the basic pay for junior doctors and dentists should be set at an appropriate level, so that earnings continue to make a medical career attractive. This means that as the hours they work come down, the need for a review of basic pay will become more urgent. For the time being, we think that it is right that basic pay be uplifted broadly in line with current inflation. We therefore **recommend** (recommendation 17) an increase of 2.7 per cent on the salary scales of all grades of doctors and dentists in training. The proposed scales are set out at Appendix A.*

CHAPTER 7: CONSULTANTS

- 7.1 *This year, we are primarily considering the pay uplift recommendation for consultants remaining on the old contract. For consultants on the new contract, we have merely been asked to endorse the 3.225 per cent uplift in consultant pay for 2004-05 and 2005-06 which was agreed by the parties in support of contract reform. The BMA and the Health Departments have also raised various other issues for consultants, some of which concern the new contract and some the old contract. Clinical academic staff are considered in this chapter, and we note here the BDA's evidence that dental public health staff will be able to move to the revised terms and conditions of service (TCS) for Hospital Medical and Dental and Public Health Medicine Staff, and that all new appointments will be made under the new TCS. We also note that this group of staff will now have access to the new consultant contract.*
- 7.2 *Our consideration of the issues raised by the parties is set out below, after the summaries of the parties' evidence.*

Reaction to the Thirty-Second Report 2003

- 7.3 The **British Medical Association** (BMA) said that our recommendation of a 3.225 per cent pay uplift for all groups had been met with mixed feelings by consultants who felt we could have been more forthright in directing how the funding set aside for the new contract should be spent. As the same uplift figure had been available to other NHS staff and was also the same (rejected) pay offer made by the Health Departments, it had been met with some suspicion.

Recruitment and retention

- 7.4 The **Health Departments** set out the latest position on consultant recruitment and retention. Consultant numbers had increased in 2002 by 1,820 (wte) or 6.6 per cent – a significant increase in the last year and faster growth than in the previous year. Consultants now represented 36 per cent of the medical and dental workforce in hospitals and public health. The Department said that the ratio of consultants to doctors in training continued to improve from one consultant for every 1.50 doctors in training in 1997, to one consultant for every 1.38 doctors in training in 2002. An increasing proportion of patient care was therefore being delivered by fully trained doctors.
- 7.5 The **Department of Health** said that 2003 NHS staff vacancy survey for England showed that the three-month vacancy rate for consultants had increased from 3.8 per cent in March 2002 to 4.7 per cent in March 2003 (an increase of 318 vacant posts (wte)), reflecting further plans for consultant expansion. Consultant posts generally took a minimum of three months to be filled, so when more posts were being created, a rise in the vacancy rate did not necessarily indicate that Trusts were having more difficulty in filling posts. The Department said that the increase needed to be seen in the context of an increase of 1,441 consultants (wte) in England over the same period.
- 7.6 The *NHS Plan* had set a target of 7,500 more consultants in England by 2004. Numbers had increased by 4,703 between September 1999 and March 2003, bringing the total to 28,024. Significant growth of 2,797 was needed to meet the 2004 target and this was a challenging objective, but the Department said it was continuing to make good progress with plans in place to deliver the target. Work was also continuing to improve data quality and figures for October 2003 indicated that significant new posts were being created. Various measures were underway to increase consultant supply – for example, support for specialist registrars (SpRs) in making the transition to consultant, and expansion of the Flexible Careers Scheme to facilitate more flexible working conditions in order to help retain doctors.

- 7.7 The Department gave figures for the 'wte to headcount' ratio for consultants in England since 1997 which showed that the ratio had remained largely stable at 0.92. We were told that the effects of part-time working were taken into account in workforce models and allowed for changes to be made to the 'wte to headcount' ratio over time. These broad assumptions were underpinned by more detailed analysis of age-based participation and leaving rates, which were also discussed with Royal College representatives. The Department said that the whole medical workforce was modelled, taking into account the age profile and grade structure. Supporting assumptions were underpinned by analysis of changing leaving and rejoining rates at each age which would implicitly take into account the effect of emerging changes in participation rates, for example, amongst staff in their 30s and early 40s. The models also took account of emerging changes in the ratio of wte to headcounts, separately at each grade.
- 7.8 The Department said that it had a number of means for monitoring retirement and retention trends and these formed an integral part of its workforce planning assumptions (which it described in some detail) and models. It said that the available evidence was consistent with workforce planning assumptions. The Department therefore remained of the view that, whilst there were some indications of a small shift towards early retirement, the numbers involved were small and would have only a marginal impact on total numbers.
- 7.9 The Department said that current data from the NHS Pensions Agency showed the number of consultant retirements for England and Wales and the reasons for retirement, but that data for voluntary early retirement in 2002 and 2003 were not currently available because these cases were still included in the 'unknown' category. However, looking at the unknown and early retirement figures together suggested no systematic increase over the last two years. Figures for overall retirements showed there was no clear trend and the total number of retirements had actually fallen in the last two years. The Departments said that the number of age retirements was higher now than in the late 1990s, but this reflected the age profile of the current workforce, rather than any change in retirement rates.
- 7.10 The last actuarial investigation (covering 1989 to 1994) of the NHS Pension Scheme by the Government Actuary's Department in 1998 had projected an average retirement age for male hospital doctors of 63.3, compared to the previous figure of 63.9 (from the 1979-1984 investigation), indicating a small change over a ten year period. This change had been reflected in the age-specific leaving rates used in the workforce models.
- 7.11 The Department commented that retirement was not the only source of leavers from the workforce, but general retention rates did not show any unwelcome trends and its workforce planning models already factored in non-retirement leavers. The Department had updated for this year's evidence the usual analysis from the Medical Careers Research Group (MCRG) on overall wastage rates five years after qualifying. This showed no clear trends over time.
- 7.12 The latest analysis of the HCHS Census Data showed that the overall wastage rate for hospital medical consultants had remained almost unchanged since 1995, with gross wastage at between five and six per cent. Appointments from outside the NHS (including rejoiners) meant the net wastage rate was now showing a 0.4 per cent gain. Gross wastage in the 55-59 age group was typically about nine per cent per year, but taking into account joiners from outside the NHS, net wastage currently stood at 6.3 per cent. The Department said there was no clear trend in the leaving rate for this age group.

- 7.13 No new MCRG data was available this year on early retirement intentions, but the Department reminded us that previous MCRG survey data had made clear that changes in pay would only have at most a marginal effect on retirement intentions. Much greater emphasis had been placed on the desire for more flexible patterns of working and general improvements to working conditions and these were a key component of the Department's HR initiatives.
- 7.14 The **Scottish Executive Health Department** (SEHD) reported that consultant numbers had increased by 104 (wte) or 3.37 per cent in 2002. The most recent six-month vacancy rate (at 30 September 2002) had remained constant at 1.9 per cent. Targets had been set in the document, *A Partnership for a Better Scotland: Partnership Agreement May 2003*, to increase the number of consultants by 600 by 2006. The **National Assembly for Wales** told us that consultants now represented 34 per cent of the medical and dental workforce in hospitals and public health. Headcount numbers had increased by 148 (ten per cent) between September 1999 and September 2002, and between 2002 and 2010, a further 525 consultants were planned. The 2003 NHS staff vacancy survey for Wales had shown that the three-month vacancy rate for consultants remained high at 8.3 per cent at March 2003, representing 183 posts, compared with 188 posts six months earlier. The Assembly reported that the changes in the ratio of whole time equivalent to headcount closely resembled the comparative English figures (the latest figures for 2002 showed the ratio to be 0.91).
- 7.15 The **BMA** said that the UK fell far below comparable countries regarding its number of doctors. In 2000, the UK had two practising physicians per 1000 population, compared with an average of 3.29 amongst European countries (OECD 2003). The target to increase consultants in the *NHS Plan* by 7,500 by 2004 recognised this problem, however the figures in both the English and Scottish *Plans* were headcount figures, not wte. With the increase in part time working, such targets might not achieve the desired outcome of increasing total consultant working hours. The BMA acknowledged that some progress had been made in recruiting more consultants with an increase in headcount of 3,749 as at September 2002, representing 50 per cent of the target for 2004. However, from the *Plan's* base year of 1999, the 7,500 target was equivalent to 1,500 a year and so the increase should have been 4,500. Progress against the Scottish target for 600 extra consultants was similarly disappointing. It said it would be interested to see the Health Departments' evidence on how consultant numbers had increased over the last twelve months. Meanwhile, the BMA said that consultants working in the NHS were delivering service increases which the Government had expected to be undertaken by new consultants.
- 7.16 The BMA welcomed the development whereby associate specialists and senior staff grade doctors were able to be assessed to determine their entry onto the specialist register, providing all doctors were judged against the same criteria and these doctors were recruited to substantive consultant posts. However, the Government's proposal to shorten training times for so-called 'generalist consultants' had been a cause of much concern and the BMA suggested that the issue should be looked at by the relevant medical Royal College.
- 7.17 The BMA drew attention to the Audit Commission's report, *Achieving the NHS Plan*, (June 2003) which it said noted 'high vacancy rates and severe workforce shortages' and 'lack of money for newly created posts'. This latter sentiment had been reinforced by evidence from the BMA's recent survey of medical directors. The BMA said that the NHS Workforce Vacancy Survey 2003 had noted that at March 2003, the three-month vacancy rate for consultants was 4.7 per cent, an increase from the 3.8 per cent

reported to us last year. In Scotland, the latest workforce statistics published by Information & Statistics Division (ISD) Scotland showed that the six-month vacancy rate for consultants was 1.9 per cent, showing no improvement from the previous year. The BMA said that 5.6 per cent of consultant posts were currently unfilled and a rise in vacancy rates greatly increased the pressure on current staff. As reported last year, junior doctors experienced pay cuts on promotion to consultant and this could encourage some holders of the Certificate of Completion of Specialist Training not to progress further.

- 7.18 The BMA hoped to be able to submit further evidence on retirements before we made our report. It noted that we had asked for further evidence on the availability of the flexible career and the retainer/returner schemes for consultants and said it would be very interested to learn from the Health Departments what the uptake had been. In the absence of any robust figures, the BMA suggested that a survey should be commissioned.
- 7.19 The **Hospital Consultants & Specialists Association (HCSA)** contended that the consultant expansion programme remained at risk, and there was some doubt as to whether the increased numbers represented a real increase in substantive NHS consultants. It urged that we recognise in our consideration of consultant remuneration that increased vacancy rates increased the pressure on staff in post.

Comment

- 7.20 *We note the Health Departments' evidence that consultant numbers for 2002 in England, Scotland and Wales had continued to grow over the previous twelve months. We welcome this continued growth, but as we have said in previous reports, it is difficult for us to judge whether the Health Departments are on track to meet their planned growth targets if we are not presented with evidence on the annual target increases. We need to take a view about the extent of any shortfall in the planned workforce and we are unable to do so without these annual figures. We would ask the Health Departments again to provide this for the next round. We also note the approaching deadline of the NHS Plan target of another 7,500 consultants (headcount) in England by March 2004, the Department of Health's evidence that a further 2,797 consultants were needed to meet the target, and the Department's comment that this was a challenging objective. We were told by the Department in the thirty-second review that the target in the NHS Plan had been informed by analysis of future staffing requirements, the numbers due to emerge from training, and the impact of proposed recruitment and retention initiatives. As well as reporting to us on whether the target was met, we would ask the Department to provide evidence on the impact any shortfall in manpower has had on our remit groups, and on the achievement of its output targets.*
- 7.21 *We note that the three-month vacancy rate has increased and that the Department of Health considers this to be the result of the creation of more consultant posts. This may well be true, but we would ask for evidence for the next round which identifies the underlying vacancy rate, excluding any growth in posts. As we said in our last report, we are unable to judge whether the increase in vacancy rate is related to the expansion of posts, or whether it is also increasing for other reasons. Any increase in the vacancy rates only serves to increase the pressure on staff currently in post. We therefore wish to keep the underlying trend under review.*

- 7.22 *We note that retention appears to be relatively stable at the moment, but that there are some indications of a small shift towards early retirement, although the numbers involved are small. It would be helpful to identify voluntary early retirements clearly in the data in order to monitor trends. The Department's description of its workforce modelling was helpful and we note that the models factor in changes in the ratio of wte to headcounts and non-retirement leavers. We also note that the latest analysis of the data showing the overall wastage rate for hospital medical consultants indicates that the rate has remained almost unchanged since 1995, and that there is no clear trend in the leaving rate for the 55-59 age group. The current trends in retention are of course important, but we also want to assess the level of threat from an unexpected acceleration in early retirements or a significant increase in part-time working. We have commented in previous reports on the need to monitor leaving intentions, as these are revealing in the context of morale and offer an indication of the possible level of threat to current staffing levels. It was therefore disappointing to see again this year that there was no new MCRG data available on early retirement intentions. We would ask for data on early retirement intentions to be made available for the next round so we may keep this under review.*
- 7.23 *The Department has reminded us that previous MCRG survey data made clear that changes in pay would only have at most a marginal effect on retirement intentions. Much greater emphasis was been placed on the desire for more flexible patterns of working and general improvements to working conditions and the Department has said that these were a key component of its HR policies. In previous rounds, the new consultant contract was seen by the parties as the vehicle for addressing the desire for flexible working patterns, which in turn was an important factor in retirement intentions. We would ask the parties for a preliminary assessment in the next round of whether the new contract is delivering this flexibility. We note that the Flexible Careers Scheme has been expanded to aid retention. In our last report, we asked for evidence of how widely available the Flexible Careers Scheme and the retainer/returner scheme were to consultants and their level of take-up. We would repeat this request for the next round and also ask the Health Departments for evidence on recent trends towards less than full-time working.*
- 7.24 *In summary, we need evidence in the following areas to enable us to consider fully the recruitment and retention situation and, as discussed above, ask for evidence accordingly from the parties for the next review on:*
- *annual staff target increases, in order to compare against actual growth;*
 - *if the NHS Plan target for consultants is not met, what impact this shortfall in manpower has had on our remit groups, and on the achievement of its output targets;*
 - *the underlying trend in vacancy rates, excluding growth in posts;*
 - *identification of the number of voluntary early retirements;*
 - *new data from MCRG on early retirement intentions;*
 - *a preliminary assessment of the flexibility in working patterns being delivered by the new contract;*
 - *the availability of the Flexible Careers Scheme and the retainer/returner scheme and their level of take-up; and*
 - *trends towards less than full-time working.*

- 7.25 *In preparing this evidence, we would also ask the parties to take into account the proposed remit change for us to have regard to regional/local variations in labour markets and their effects on recruitment and retention, and to consider how the information requirements we discussed with regard to this in chapter 1 might also impact on the information requirements requested here.*
- 7.26 *For this round, the threat to the achievement of the Departments' output targets from an acceleration in early retirement or a move towards more part-time working is likely to be linked to the current state of consultants' morale, which we consider below.*

Morale, motivation and workload

- 7.27 The **BMA** considered that a consequence of the UK being 'under-doctored' was that workload and work intensity was high. It said that the results from its survey of English consultants, following the October 2002 rejection of the contract, to which nearly 11,000 consultants had responded, supported the results from previous research on workload done by KPMG and MORI in 1998. The majority of consultants worked very long hours for the NHS with the 2002 research showing that 77 per cent of consultants worked more than 50 hours per week, and that 46 per cent worked more than 60 hours per week. This extra work was usually unremunerated. The research had also shown that 28 per cent of consultants were on the highest banding for intensity payments.
- 7.28 The BMA said that the NHS had been subject to almost perpetual change in the last decade and this had sapped the morale of almost all NHS staff, not least consultants. An increasingly centralised and managed health service seemed to have less respect for the professionalism and clinical autonomy of the consultant. This had been highlighted by the rejection of the consultant contract in England and Wales last year when one of the major problems was that Trust managers would have been given too much control over consultants' workload, conceivably allowing clinical care to be directed to fulfil political targets. The BMA considered that the increasingly difficult relationship between managers and clinicians clearly needed to be given urgent consideration. The decline in these features of consultants' working lives had lowered the morale of consultants as much as direct concerns about pay. The BMA said that as the Government undermined the positive aspects of an NHS career, so pay became ever more important as a measure of society's valuation of this group.
- 7.29 The BMA told us that its 2002 survey had confirmed that the majority of consultants were in breach of the European Working Time Directive (EWTD) by working over 48 hours per week¹. The new contract should help to control workload, but the BMA said it was aware of trusts attempting to require consultants on the new contract to continue working over 48 hours without paying them for the extra work. We were strongly urged to take action to ensure implementation of the EWTD for senior hospital doctors.
- 7.30 The **HCSA** said that workload pressures had again risen to unacceptable levels. Any consideration of morale in this round could not ignore the first rejection of the contract and subsequent developments. The HCSA quoted the results of the *Health of the Profession Survey*, undertaken by *Hospital Doctor* in July 2003 which, it said, revealed how deep-rooted consultants' problems were – a majority of respondents considered workload had increased (with some consultants working very long hours or high intensity on-call rotas), clinical autonomy had decreased, Trust management was unsupportive, morale was poor and had declined in the past five years, consultants were suffering stress, and their job prevented them from having enough time with their

¹ The Department of Health has confirmed that career grade doctors can choose to work more than 48 hours a week over a 26-week reference period.

family. A majority of respondents also thought their salary was too low (surgeons being the least happy with salary) and they were planning to retire early. We were therefore invited to consider seriously the very real workload and responsibilities of senior medical staff. The HCSA believed that its call last year for a minimum five per cent pay uplift remained valid. It considered that we had a pivotal opportunity to redress the historical under valuation of senior medical staff and we were urged to grasp it.

- 7.31 The various HR initiatives which have been put in place by the **Department of Health** to improve morale and motivation for all staff groups were described in more detail in chapter 1. They included a new national staff opinion survey, childcare strategy, provisions for maternity, paternity and adoption leave, the Flexible Careers Scheme, and Flexible Retirement Campaign.
- 7.32 In supplementary evidence, the Department of Health said that it had looked again at our interpretation of the BMA survey in the light of the comments at paragraph 2.55 of our Thirty-Second Report. The Department said that only ten per cent of the consultants in the BMA's survey were part-timers, and the majority of the part-time consultants in the survey worked seven or more notional half days. Ignoring the part-timers would result in a revised estimate of 48.9 hours for full-time consultants and would suggest that consultants' hours had indeed reduced since the MORI survey.
- 7.33 Responding in further supplementary evidence to these comments, the **BMA** said that it calculated that the standard error of the mean from its workload enquiry was of the order of 1.3 hours. Even accepting the Department's arguments, there would be overlap between the confidence limits around the two surveys, and this would, on the face of it, suggest no significant difference. The BMA said that the intensity involved in existing workload had been increased by the smaller amount of clinical time available to individual consultants as a result of non-clinical workload associated with management and clinical governance. The BMA also said that another interesting feature of its survey was that the median for whole-timers was 52 hours, which was bigger than the mean. This suggested a skew to lower values. The BMA said it would be interesting to know if the MORI survey showed this as well. If it did not, this might suggest that the BMA's results were downward biased and this could be due to the two samples having a different age/sex/specialty mix.
- 7.34 The **SEHD** said that over 3,000 consultants had now benefited from annual appraisal, linked to revalidation.

Comment

- 7.35 *As we said in chapter 1, we welcome the long-awaited introduction of the national staff opinion survey, as this should provide a baseline against which we can consider changes in morale. We look forward to receiving further evidence on this for our next review.*
- 7.36 *The BMA has argued that consultants' workload and work intensity remain high, with a majority working in breach of the EWTd, and we are asked to take action to ensure the implementation of the EWTd for senior hospital doctors. Implementation of the agreement on the EWTd for consultants can only be ensured by the employers, but we would repeat the comments made in our last report. We expect the agreement to be properly implemented (while recognising that additional consultants are part of the solution here), and we hope that any remaining problem areas will be resolved quickly. We would expect the Health Departments to monitor this carefully and to report to us on implementation of the agreement in the next round. We would also ask the Health Departments again for evidence that the staffing implications of the EWTd have been taken into account in workforce planning.*

- 7.37 *The BMA also argues that the changes in the NHS over the past decade have sapped the morale of almost all NHS staff, including consultants, and that this was highlighted by consultants' rejection of the original contract in October 2002. In previous evidence, the Department of Health has said that one of the solutions to morale problems was increased staffing and the new contract offering career flexibility. When we considered the issue of morale in the last round, the outlook was generally bleak. Consultants had rejected the original contract and the Department's alternative proposals had met with little support. At that time, we considered there to be a real danger of an acceleration in the rate of early retirement or switching to part-time working. However, the evidence presented by the Department of Health for this round does not indicate this has happened and, most significantly, a majority of consultants has now voted to accept the revised contract framework.*
- 7.38 *A key feature of the new contract is its ability to allow consultants to have better control over their workload. We hope that the new contract will achieve this and will await further evidence on its effect on workload, and consequently morale, for our next review. The contract is of course optional, but it does offer consultants the means of controlling workload, which has been a key concern for consultants for some years now, in a way that the old contract appears not to have done. We would therefore ask the BMA for evidence in the next round on why consultants are choosing to remain on the old contract, and what use this group are making of the existing job planning procedures in order to address concerns about workload.*
- 7.39 *Consideration of consultants' morale was very much influenced in the last round by the events surrounding the rejection of the original contract. Events have moved on and we wish to reserve judgement for now on the state of consultant morale and its impact on consultants' continuing commitment to the NHS while the revised contract is introduced and there has been some wider experience of its operation. We would however ask the parties to let us have a preliminary assessment for the next round.*

The new consultant contract

- 7.40 The **Department of Health** said it very much welcomed the recent outcome of the BMA's ballot of consultants and SpRs in England on the new contract, which had followed from talks to address consultants' main concerns about the 2002 proposals. The modified features of the contract included:
- a clause had been written into the contract requiring non-emergency work at evenings and weekends to be by agreement;
 - no enhanced recognition for work in evenings and weekend mornings – evening and weekend sessions would be reduced from four hours to three hours;
 - clarification had been given on appropriate managerial control; and
 - all consultants to offer one session of four hours per week to the NHS before doing private practice, and all consultants to devote normally three-quarters of their time (seven and a half sessions per week on average) to direct patient care.
- 7.41 In September 2003 the Department said that the parties had agreed a more detailed package of documentation to support the new contract and new Clinical Excellence Award Scheme (CEA), based on the original June 2002 framework and the July 2003 'Heads of Agreement'. The Department said the recent ballot result, in which 61 per cent of consultants in England and 55 per cent of SpRs supported this package, was a

very welcome outcome. It had been agreed with the BMA that consultants giving a formal commitment to the new contract by 31 October 2003 would receive pay increases backdated to 1 April 2003. A commitment given between 1 November 2003 and 31 March 2004 would backdate pay increases three months from the date of commitment. In both cases, backdating would be conditional upon a job plan being agreed within three months. The Department said that, subject to the levels of take-up, investment in consultants' pay for 2003-04 would be as previously planned (an estimated extra £133 million), resulting in average earnings increases of 5.9 per cent.

- 7.42 The revenue allocations for the additional cost of the contract in 2004-05 and 2005-06 were, respectively, £186 million and £250 million. A further £7.5 million and £15 million for these two respective years would be made available to support agreed annual leave improvements. The Department said that together with the BMA and the NHS Confederation, it was seeking our endorsement of a 3.225 per cent pay award for 2004-05 and 2005-06 to give effect to years two and three of the agreed ten per cent three-year pay deal that was part of the original June 2002 framework.
- 7.43 The Department summarised the main provisions of the new contract, the resulting benefits to the NHS, and the benefits to consultants – a 15 per cent increase in average career earnings; more effective job planning, enabling the reduction of excessive workload; and a contract based on agreed time and service commitments which recognised on-call duties more consistently and equitably.
- 7.44 The **Scottish Executive Health Department** (SEHD) said the contract would be crucial to modernisation of the NHS, improving recruitment and retention, and helping consultants to address overall workloads. The SEHD said that 78.7 per cent of consultants in Scotland had voted in favour of the new contract.
- 7.45 The **National Assembly for Wales** said that following the 'no' vote in October 2002 in Wales, negotiations had taken place with the BMA about maximising the rewards and benefits of the current consultant contract. The subsequent Welsh deal was not, and was never intended to be, a new contract. The changes currently being piloted were a modification of the current contract of employment, but influenced by certain aspects of the original agreement. The main differences to the English and Scottish agreements were:
- a system of commitment awards to be paid every three years after reaching the new maximum on the pay scale, replacing the former discretionary points;
 - a basic 37.5 hour working week, but consultants would give freely an additional session, guaranteeing 41 hours per week; and
 - the new salary structure with two extra incremental points, reflecting the fact that 70 per cent of existing consultants in Wales were on the maximum of the existing scale.
- 7.46 The Assembly anticipated that the amended contract would help to attract new consultants into Wales, which would benefit areas where vacancy rates were higher. While it believed that it was very important for the four countries to maintain a united stance on pay and reward systems, the Assembly said it had devolved powers for pay and terms and conditions of service in order to secure patient care for the people of Wales. The contractual changes that had been negotiated reflected the particular problems and issues faced in Wales on recruitment, retention and performance of NHS consultants.

- 7.47 The **NHS Confederation** said that markedly different contracts were now on offer for consultants in England, Scotland and Wales and this was clearly going to pose specific challenges for us in future years. However, the Confederation said it was extremely pleased that consultants in England had voted so clearly to accept the new contract and it hoped that consultants in the other countries would also vote to accept their contracts. There was now a considerable task of implementation. The Confederation hoped that it would now be possible to move forward, and for NHS management and the medical profession to build greater trust and to work together on improving the service for patients. Part of the agreement in England was a joint recommendation for a pay uplift of 3.225 per cent per annum for consultants taking up the new contract for 2004-05 and 2005-06, with no changes to the pay structure. This was, the Confederation said, in effect years two and three of the original proposal for a three-year pay deal. The agreements in Scotland and Wales made similar recommendations which the Confederation would endorse.
- 7.48 Like the Health Departments, the **BMA** also described the developments regarding the consultant contract in England during 2003, summarising the 'Heads of Agreement' reached between the parties last July after discussions with the new Secretary of State². In the resulting ballot of all consultants and SpRs in England, an overall 60 per cent majority of both consultants (61 per cent) and SpRs (55 per cent) voted in favour of the new contract. The Central Consultants and Specialists Committee had accepted the contract on the proviso that current consultants could remain indefinitely on the old contract, retaining the right to transfer to the new one at any time.
- 7.49 In Scotland, the BMA said some key changes to the 2002 framework had been agreed and the result of the Scottish ballot was that 78.7 per cent of consultants and SpRs were in favour of the new contract. Scottish terms and conditions were similar, but not identical, to those in England. In Wales, agreement between the Welsh Consultants and Specialists Committee and the Welsh Assembly had been reached during the summer. Welsh consultants and SpRs were currently being balloted³. If the agreement were implemented, consultants would have no choice but to move onto the new contract.
- 7.50 Under the terms of the new consultant contract agreement, the BMA said that the Health Departments and the BMA jointly recommended to us that consultants in England and Scotland who wished to take up the new contract would be tied to the agreed payscales, uplifted by ten per cent over three years (i.e. 3.225 per cent per year), taking effect from the point of implementation, i.e. 1 April 2003. For consultants in Wales, a 3.225 per cent pay uplift would apply to the agreed payscales from April 2004 and again in April 2005, subject to the contract's acceptance. The BMA said that it was important for the new contract's payscales to remain favourable in recognition of the particular recruitment and retention problems in Wales. Supplementary evidence would be submitted on the ballot outcome.

Comment

- 7.51 *We have commented in previous reports on the importance of a successful negotiation of a new contract and so we were pleased that a clear majority of consultants in all three countries voted to accept the new contract. We shall await with interest evidence for the next round showing how many consultants in England and Scotland have opted to take it up, and*

² The BMA's evidence said that work done in premium time will be paid at time and a third, whereas the Department of Health said that session time will be reduced from four hours to three.

³ On a turnout of 64.9 per cent, 94.2 per cent of consultants and specialist registrars working in Wales voted in favour of the new contract.

a preliminary early assessment from the parties in all three countries of its effectiveness in controlling consultants' workload, improving morale and aiding retention. We would also ask the parties for a preliminary assessment of the impact on service delivery, consultants' remuneration, and on Trusts' budgets.

- 7.52 *As requested by the parties, we duly endorse and **recommend** (recommendation 18) a 3.225 per cent pay uplift for 2004-05 and for 2005-06 for those consultants on the new contract, in order to give effect to years two and three of the agreed ten per cent three-year pay deal. The recommended pay thresholds are set out at Appendix A.*

Pay elements of the new contract

- 7.53 The **BMA** said it wished to clarify its expectations of our future role in making recommendations on the new contractual arrangements. Recent examples were cited of salaries being advertised for consultant posts which were well in excess of the top of the new salary scales. In the BMA's view, market forces had moved pay rates on since the pay scales were agreed, and the contractual changes agreed by GMPs and other NHS staff groups under *Agenda for Change* had impacted upon consultants' perceptions of the acceptability of the new basic salaries. We were requested to conduct a major review of the appropriateness of the consultant salary scales with a view to making recommendations for implementation in April 2006.
- 7.54 The BMA said that additional programmed activities worked beyond the standard ten were low-cost for Trusts as they were not superannuable. This could provide a perverse incentive to use them to deliver extra activity rather than expanding consultant numbers. We were therefore asked for additional programmed activities to be paid at a higher rate than standard to reflect these concerns and recognise that they were not superannuable. The BMA said this would usually be regarded as being worth around 20 per cent on basic salary.
- 7.55 The BMA asked us to increase substantially the supplements for on-call availability. A consultant with the highest frequency of on-call rota would receive a supplement of eight per cent of basic salary which was felt to be too low. The BMA believed that a survey should also be commissioned to consider out-of-hours and on-call work and its disruption to family life, which would inform any review of on-call supplements.
- 7.56 The BMA said that it expected us to have a future role in making recommendations about the enhanced recognition of work undertaken in premium time. The current provision allowing such work to be paid at time and a third was believed to be inadequate, comparing poorly with other NHS staff under *Agenda for Change* who could be paid at roughly time and a half. Increasing payments would encourage Trusts to schedule work at other times.
- 7.57 The **HCSA** said that consultants found they were having to increase output to meet the political imperative at the expense of true clinical needs. This was contributing to a negative attitude within the profession. Consultants were also donating considerable free time to delivering quality care, and their workload had been exacerbated by the increased demands for training junior medical staff and by the reduction in juniors' hours. Goodwill, motivation and morale of consultants was being rapidly affected with HCSA members retiring early and others leaving the UK to work overseas. Others were so disaffected with the NHS that they would only do what was necessary to fulfil the terms of the new contract. The HCSA said this would have a negative impact on overall NHS capacity and Trusts would have significant implementation difficulties.

Comment

- 7.58 *It was helpful of the BMA to clarify its expectations of our future role in making recommendations on the new contractual arrangements. We would also expect to resume our role in making recommendations once the current three-year pay deal expires for those on the new contract, subject to any agreements the parties may wish to negotiate directly.*
- 7.59 *For this round, the BMA has highlighted its concerns about some aspects of the new contract, and asked us to make recommendations about certain aspects. We are also asked to conduct a major review of the new salary scales, in readiness for resuming our traditional role in April 2006, and to commission a survey on out-of-hours and on-call work. We understand that the BMA may be unhappy with some aspects of the contract arrangements, and that the passage of time is always likely to make an agreement seem less favourable in comparison to one agreed more recently. However, we consider that the agreement on which consultants were balloted last autumn should stand as negotiated while the three-year pay deal runs its course. The new arrangements have had no time as yet to start operating widely within the NHS. Only when the contract has been operating widely for a period of time can an assessment be made about any shortcomings and areas which may need to be reconsidered. We have therefore noted the BMA's particular concerns and would ask the parties to provide us with further evidence on these issues (or any other issues of concern) for our next review so we can monitor how the contract is operating in practice.*

Consultants on the existing contract

- 7.60 The **Department of Health** said that existing consultants would have the choice of whether to move onto the new contract and it was likely that some would remain on current national terms and conditions. The Department said it had worked hard with the BMA to pitch the benefits of the new contract for consultants (compared to their current contract) at a level that could be justified by the benefits for patient care. It stressed that a disproportionate increase in pay, or any structural changes to the pay system for consultants remaining on current terms and conditions, would upset this balance and generate further instability and uncertainty for NHS Trusts. For these reasons, it said it had reached an "understanding" with the BMA in 2002 that the ten per cent three-year pay deal would apply equally to all consultants. The Department considered this was still the sensible way forward. We were invited to confirm that 3.225 per cent awards in 2004-05 and 2005-06 should apply equally to consultants on current national terms and conditions.
- 7.61 The **SEHD** said it was seeking our endorsement of 3.225 per cent pay awards for consultants for 2004-05 and 2005-06. The **National Assembly for Wales** supported a 3.225 per cent increase being applied across the board for consultants.
- 7.62 In supplementary evidence, the **Department of Health** said that it was simply not true to say, as the BMA had said in its general evidence on the level of the pay uplift for 2004-05⁴, that the across the board offer to all hospital doctors of a ten per cent deal over three years was designed to make investment available for the contract. The Department said that, as was explained in the June 2002 agreed framework document, the purpose of the three-year deal was "to promote underlying stability in pay during [the] transitional period" during which the contract was being implemented. The Department explained that Section 9 of the June 2002 framework agreement went on to say that "the parties to the talks have also agreed to make joint recommendations to

⁴ See paragraph 1.96.

the Doctors' and Dentists' Pay Review Body on the general pay awards that should be made to consultants in the three years from April 2003" (the Department's underlining). The Department said that whilst this could arguably have been made more explicit, it was certainly its understanding that this represented an agreement that the ten per cent three-year pay deal should apply equally to all consultants, whether or not they took up the new contract. It said it was therefore disappointed that, following this year's revised agreement on the new contract, the BMA had declined to continue supporting this approach. The Department said it continued to believe that a ten per cent three-year deal for all consultants was a sensible way forward, and it could see no case for an award of more than 3.225 per cent for consultants remaining on the old contract.

- 7.63 However, in further supplementary evidence, following the Health Departments' oral evidence session, the Department of Health modified its position regarding consultants on the old contract. It had said in written and supplementary evidence that it would continue to support a ten per cent three-year pay deal for all consultants, including those who chose not to take up the new contract. The Department said this had been on the basis of (it had thought) having agreed such an arrangement with the BMA in July 2002, and in view of the benefits that a multi-year deal would bring for financial and service planning. The Department said that the BMA had now put beyond any doubt that it did not support a three-year deal of this kind. In oral evidence the Department said it had indicated to us that in its view, there was no longer a case for an award of 3.225 per cent, and that this put consultants on the pre-2003 contract onto the same footing as other grades of hospital doctor, for whom it was seeking a 2.5 per cent uplift. The **SEHD** also confirmed that it was content to follow this revised approach.
- 7.64 In its evidence, the **NHS Confederation** said that for those consultants choosing to remain on existing terms and conditions, it had been disappointed that the BMA had not chosen to recommend a similar pay uplift arrangement on a joint basis. At this stage, it would be extremely disruptive for there to be any differential award to consultants remaining on the existing contract, or for there to be any changes to the current structure. A similar two-year award of 3.225 per cent per annum for 2004-05 and 2005-06 with no changes to the pay structure was therefore proposed. The Confederation emphasised that this was an important issue for the NHS employers and urged us not to underestimate the potentially divisive and damaging effect of any other differential recommendation.
- 7.65 The **BMA** commented that consultants opting to remain on their existing contract were subject to the same workload pressures as those moving to the new contract. As it had set out in its evidence (see chapter 1), this group needed to receive a minimum increase in pay rates of five per cent from 1 April 2004 to avoid losing ground against comparators, and in view of the BMA's evidence on recruitment and retention, workload and intensity, centralisation and managerial control. The BMA said we would be aware that there was no agreement with the Health Departments that consultants choosing to remain on the current contract should be tied to the same three-year pay deal as their colleagues moving to the new contract.
- 7.66 The BMA said that the current contract did not include any specific provisions for rewarding work done outside of normal working hours, or a consultant's on-call duties. Usually this type of work went unrecognised⁵ and the BMA quoted its survey of consultant opinion which had found that 71 per cent of respondents out-of-hours duties were not recognised or rewarded in any way. Whilst this problem had been addressed to some extent in the new contract, there might be valid reasons for some consultants opting to stay on the current contract and there needed to be some recognition for work done at unsocial times.

⁵ The out-of-hours intensity payments supplement gives some financial recognition of additional hours worked.

- 7.67 In supplementary evidence, the BMA said that it was never its understanding that the ten per cent three-year pay deal agreed as part of the negotiations on the new consultant contract should apply to any group of doctors other than those consultants employed under the new contract. It said it was therefore incorrect of the Department to report that this year “the BMA declined to continue supporting” the approach that the pay deal was applicable to all consultants. It said that it did indeed decline an offer for the deal to be extended to other consultants, but had never previously been party to such an agreement.
- 7.68 Responding to the Department of Health’s subsequent proposal for a lower increase (of 2.5 per cent) for those consultants remaining on the existing contract, the BMA said that it was worth repeating that remaining on existing contracts where permissible had no implications for any of the criteria for pay settlement set out in our terms of reference. The BMA said that neither workload, living costs, comparability or retention were altered by failure to opt for a new contract and that it was sensible to reward these doctors in a way which reflected the boundaries set by the new contracts. The BMA said that these, at the minimum, guaranteed doctors a revaluation of 3.225 per cent per year, and at the maximum, created opportunities for significantly higher earnings.
- 7.69 In response to our request at oral evidence for an explanation as to why some consultants might opt to remain on the existing contract, the BMA explained in supplementary evidence that consultants on maximum part-time contracts might take this course for a number of possible reasons. The BMA said that they would not favour the transitional arrangements whereby their pay increases were phased in until April 2005. The BMA also said that they were almost certainly undertaking private work and would thus be unhappy about the requirement to offer an extra programmed activity before undertaking private work in order to maintain pay progression. Notwithstanding their long hours of work (which were close to those of whole-timers), the BMA said that their working week was, at least in theory, less circumscribed than that of the whole-timer at present and they might resent the extension of nominal control over professional time under the new arrangements.

Comment

- 7.70 *In approaching our deliberations on the level of the pay uplift for consultants who choose to remain on the existing contract, we were mindful of our views from previous rounds about the need for a new consultant contract. We have said in previous years that the importance of the successful negotiation of a new contract was clear to us, and that it was clear that the parties also saw the new contract as the solution to many of the key issues facing the profession. We commented earlier in this chapter that we want to see a preliminary assessment for the next round of the effectiveness of the new contract in controlling workload, improving morale and aiding retention. The old contract did not appear to be able to offer consultants the means of controlling their workload and this in turn was affecting morale. We therefore see the new contract as the means by which consultants can take better control of their workload, and we expect this to deliver benefits for morale in time.*
- 7.71 *We note that the parties dispute whether there was any agreement that the ten per cent three-year pay deal being offered in support of the new contract would also apply to those consultants remaining on the existing contract. During the course of this round, the Department of Health withdrew its proposal that 3.225 per cent should also be recommended for these consultants in 2004-05. The Department is now seeking a recommendation in line with the Government’s inflation target of 2.5 per cent. The BMA is seeking a minimum increase in pay rates of five per cent to take account of comparators, and in view of its evidence on recruitment, retention, workload and intensity, centralisation and*

*managerial control. We have considered the parties' arguments carefully. In our view, the solutions to the problems of workload, morale and a desire for greater career flexibility are intended to be addressed through the new contract and we have said that it is our intention not to disrupt what has been agreed between the parties and accepted by our remit groups in their contract ballots. The decision about whether to stay on the existing contract will be a personal one, and will take into account a range of considerations for the individual concerned which may be of no relevance to our particular remit. We therefore support the Department's view regarding the uplift and consequently **recommend** (recommendation 19) an increase of 2.5 per cent for 2004-05 on the national salary scale for the existing contract (the pre-2003 contract). The recommended paycales are set out at Appendix A.*

Collaborative fees

- 7.72 The **Department of Health** said that for consultants on the new contract, regular work undertaken on behalf of a local authority or Government Department should generally form part of NHS programmed activities, with no fee payable to individual consultants unless they and their employing organisation agreed that the work involved minimal disruption. For consultants remaining on the old contract, and for any such work undertaken outside NHS programmed activities by consultants on the new contract, the Department said it was seeking a recommendation from us for a 2.5 per cent uplift.
- 7.73 In supplementary evidence, the Department said it strongly felt that payments under these arrangements should be kept in line with NHS earnings. It considered that the work covered by the collaborative arrangements for hospital doctors ought, wherever possible, to be scheduled into the working week through job planning and remunerated as part of salary. The Department said this reflected the arrangements agreed in the new contract to promote much greater transparency in relation to fee-paying work and prevent consultants being effectively paid twice for work done in NHS time. Including this work as part of scheduled NHS activities would mean that it became pensionable for hospital doctors. The Department therefore asked us to take account of the fact that this had sharply increased the value of work done under the collaborative arrangements, and said it did not believe that any further increase to the value of the fees was justified.

Comment

- 7.74 *We note that the Department of Health now intends work done by consultants under the collaborative arrangements to form part of their programmed activities. We commented further on collaborative fees and give our recommendation for 2004-05 in chapter 2 on GMPs.*
- 7.75 *We would however, ask the Department of Health for evidence in the next round on the number of job plans which have been taken to arbitration and why. Until such time as the Department of Health informs us that separate fees for consultants carrying out work under the collaborative arrangements have been abolished, or until the fees are reviewed by the Departments or Agencies concerned, we will need to continue to recommend on these fees and our recommendation was set out in chapter 2.*

Discretionary points, distinction awards and the new Clinical Excellence Award scheme

- 7.76 *The BMA has raised with us the value of higher awards under the new Clinical Excellence Awards scheme in England and highlighted that it did not agree the scheme with the Department of Health. It has also raised its concern about the need for equitable funding arrangements for the new scheme in Wales and asked that the distinction awards scheme in*

Scotland, which will continue in 2004-05, should be based on the new consultant salary scale. The Health Departments have responded to these proposals in their evidence, and the Department of Health has proposed that the value of the awards should be uplifted by 3.225 per cent, in line with the proposed uplift in consultants' pay. The parties' evidence is summarised below. Our recommendations are set out at the end of this section.

- 7.77 The **Department of Health** said that the package on which consultants in England were balloted in September included the key features of the new Clinical Excellence Award scheme (CEA), which would replace discretionary points and distinction awards. The new scheme would start to be introduced later this year with the first awards payable in 2004-05. It said that the new scheme would be more open and transparent, would more fairly reward the greatest sustained levels of performance and NHS commitment, and its criteria would reflect the standards of quality and commitment expected of consultants. It would be open to all consultants of at least one year's service. There would be twelve levels of award. Levels 1-8 would be awarded by local (individual employer) committees; level 9 could be awarded either by local committees or by the new Advisory Committee on Clinical Excellence Awards (ACCEA), depending on the type of achievement being recognised. Levels 10-12 would be awarded by ACCEA. The 2003-04 values of the awards were – Levels 1-8, £2,617-£26,170; Level 9, £31,404; Levels 10-12, £41,290-£67,097.
- 7.78 The Department said that the ratio of new local awards to eligible consultants would continue to be a minimum of 0.35 to one per annum. As CEAs were being extended to all consultants with at least one year's service, in order to accommodate the wider pool of eligible consultants, the unit value of the lower CEAs was slightly lower than the current unit value of discretionary points. However, the total annual level of investment in new awards at local level would be at least the same as it had been for discretionary points.
- 7.79 For 2004-05, the Department proposed that the value of CEAs should be uplifted by 3.225 per cent, in line with the proposed uplift in consultants' pay, to give stability during the introduction of the new scheme. The Department said that it had agreed with the BMA that investment in the four highest levels of award should be the same as would have occurred under a system of distinction awards. It therefore proposed that the budget for these higher awards (including the distinction awards that would remain in payment until the award holders retired or received a higher CEA) should be based upon the 2003-04 budget for distinction awards, increased in line with the proposed 3.225 per cent uplift in the unit value of awards and the projected growth in the numbers of eligible consultants. The Department also proposed that the number of new awards to be made at each of the highest levels should be determined by ACCEA, having regard to the growth in the budget and the funding and number of awards released at each level through retirements, resignations, withdrawals and progression through the scheme.
- 7.80 The **SEHD** said that it was about to start talks with the BMA in Scotland on how to redistribute the resources currently used for Scottish distinction awards and discretionary points. The intention was to complete the process by spring 2004. The **National Assembly for Wales** said that it had used the funding for the former discretionary points scheme to introduce a commitment award scheme linked to continuing and consistent high performance and quality outcomes. The system of commitment awards would be paid every three years after reaching the maximum of the new pay scale.

2002 round for distinction awards

- 7.81 The Chairman of the **Advisory Committee on Clinical Excellence Awards** (ACCEA – formerly the Advisory Committee on Distinction Awards (ACDA)) reported on the outcome of the 2002 round for England and Wales. In 2002, the percentage of women receiving 'A+', 'A' and 'B' awards was reported to be, respectively, 12.9 per cent, 14.4 per cent, and 16.9 per cent. In 2001, the respective figures were 8.3 per cent, 14.5 per cent, and 18.6 per cent. Consultants from ethnic minority backgrounds had received 7.4 per cent of awards in 2002, compared to 6.4 per cent in 2001; the number of consultants receiving 'A+' awards was reported to have dropped, but the percentages for 'A' and 'B' awards had increased. The Chairman said that the higher percentage at 'B' level suggested that, in due course, the percentages would increase for all those receiving higher awards. The Chairman also said that the Committee remained concerned to ensure that all under-represented groups should be treated fairly, and that nominees should be judged fairly and transparently against objective criteria. However, the Chairman commented that if the number of awards made to women and those from ethnic minority backgrounds were to increase, ACCEA would need to receive a greater number of nominations in support of them.
- 7.82 The Chairman said that past reports had highlighted the Committee's concern over the marked differences in the distribution of awards, including differences between specialties, and so ACDA had produced a Report on the Distribution of Awards in February 2003. We were also told that an independent and much more detailed analysis of this and other data had been undertaken by Professor Michael Goldacre and Dr Trevor Lambert of the Department of Epidemiology of the University of Oxford. The Chairman said that the Committee hoped this would be published shortly, and the Committee would include further information on this in next year's evidence.
- 7.83 The Chairman of the **Scottish Advisory Committee on Distinction Awards** (SACDA) reported that SACDA had completed its fourth (2002) awards round in September 2002 and had issued its Annual Report in March 2003.

2003 round

- 7.84 The Chairman reported that **ACDA** met for the final time on 7 October 2003 to agree the allocation of awards for the year. She also said that in order to ensure that no artificial barriers existed to the free movement of consultants between England, Wales and Scotland, ACDA had maintained close contact with colleagues in SACDA to ensure that cooperation continued under the new arrangements. At its final meeting, the Chairman said that ACDA had allocated 38 'A+' awards, 143 'A' awards, and 329 'B' awards. In 2003 the Chairman reported that 8.2 per cent of 'B' awards went to consultants from an ethnic minority background, and 19.7 per cent went to women. The Chairman commented that this was very encouraging for future years. The Chairman also thanked the Chairmen and Medical Vice-Chairmen of the Regional Advisory Committees for ensuring punctilious assessments of awards at the five-year reviews.
- 7.85 The Chairman of **SACDA** reported that the Committee had met on 25 September 2003 to agree the final allocation of awards in Scotland for the 2003 round, and had approved 60 awards, including 12 additional awards endorsed under our thirty-second review. The awards comprised six 'A+' awards, 17 'A' awards, and 37 'B' awards. The Chairman commented that, as with earlier years, a relatively low proportion of female consultants were nominated in the 2003 awards round, which, the Committee believed, was partly due to female consultants being younger, on average, than male consultants.

Of the 46 female nominations (13.3 per cent of all nominations), seven were successful (11.7 per cent of awards granted). As at 30 September 2003, there were 455 award holders in Scotland comprising 13.1 per cent of all consultants. In supplementary evidence, the Chairman said the committee noted the lower number of awards available this year, lower than 2002 and substantially lower than 2001. He said the impact of this had been a slight decrease in the proportion of the total consultant population receiving an award.

2004 round

- 7.86 The Chairman of **ACCEA** said that in previous years, the ACDA and the SACDA had put joint proposals to us for increases in the numbers of distinction awards (on a Great Britain basis), in line with the growth in consultant numbers. Since distinction awards would continue to be awarded in Scotland in 2004-05, but in England and Wales all new awards would be made under the CEA scheme (with four higher awards of different values), the Chairman said that this joint approach was no longer appropriate, and therefore SACDA was submitting separate evidence.
- 7.87 The Chairman of **SACDA** reported that the committee had chosen to submit separate evidence this year because of the change in the awards structure in England and Wales which had made it more complex to write a combined paper. However, the Committee stressed its wish to maintain the coherence of the systems north and south of the border, and said it had taken some trouble to maintain close contacts with ACDA/ACCEA and that their respective views on the operation and importance of the respective schemes were close. He said that the SEHD had determined that there should be a review of the Scottish scheme, this was due to start in December 2003 and it was impossible to predict the outcome. Bearing these points in mind, SACDA said that it was recommending the maintenance of the current proportion of consultants in Scotland receiving awards in 2004. However, the Chairman noted that the number of consultants in Scotland had increased significantly in 2003. In order to avoid a significant decrease in the proportion of consultants receiving awards, he said that the Committee pointed out that the adjustment in awards should be an additional two 'A+' awards, seven 'A' awards, and fifteen 'B' awards.
- 7.88 The Chairman of **ACCEA** commented that this was a time of great change for the awards process in England and Wales. The Chairman said that the Distinction Awards scheme was being replaced by the new CEA scheme, which would incorporate in a single spine the old distinction awards and the discretionary points system, which was run by Trusts. The discretionary points would become Clinical Excellence Awards Levels 1-8, and these would continue to be financed by NHS employers. There would be a new Clinical Excellence Award Level 9, which may be awarded by either the ACCEA or local committees, depending on the type of achievement being recognised. Clinical Excellence Awards Levels 10-12 were the new national level awards. Level 9 would be known as Bronze, Level 10 as Silver, Level 11 as Gold, and Level 12 as Platinum.
- 7.89 In contrast to the old discretionary points and distinction awards schemes, the Chairman said that all awards under the new scheme would be determined according to a common rationale and objectives. Eligibility standards and assessment criteria *for all awards* were set nationally, and ACCEA's sub-committees would monitor the operation of the local schemes. Consultants currently in receipt of a distinction award or discretionary points would keep them, subject to the existing review provisions, and they would also be eligible to apply for higher CEA awards. However, the award of a CEA would subsume the value of any discretionary points or distinction award already held by the consultant.

- 7.90 The Chairman said the Committee understood that the Department of Health had proposed that the financial envelope for the four national levels of CEA would be that of the 2003 ACDA quantum, uprated by 3.225 per cent, and increased pro rata with the national increase in consultant numbers. Thus the pot would be divided among four CEA levels (Bronze, Silver, Gold and Platinum), rather than the three levels (B, A, and A+) of the distinction awards. The Chairman commented that the Department had also proposed that, in future, ACCEA should decide within a financial envelope determined by the Department, how many national awards should be made at each of the four levels.
- 7.91 The Chairman said there were implications to these proposals. If there were to be four national awards, funding for each should be according to a robust formula which determined the number at each level. The Chairman commented that identifying this had, in the past, been our role. If the four levels were to be apportioned out of the fund presently available for three, there would have to be a smaller base number at each level than was the case at present. The Chairman said that this was something we may want to consider at this early point in the new scheme.
- 7.92 The Chairman said that the Committee's proposals for the 2004 awards round reflected the change from distinction awards to CEAs in England and Wales, including the replacement of the three levels of higher awards with the four CEA levels. The proposals also maintained the same level of investment for the new award scheme that would have occurred under the previous arrangements. The Chairman said that the budget for higher awards should be increased in line with the increase in the number of doctors eligible for an award, and that ACCEA should also be given the flexibility to determine the number of awards to be made at each level. In the year to 30 September 2002, the consultant population in Great Britain had increased by 5.5 per cent. The Chairman said that in England and Wales, if the distinction awards system had still been in operation, the Committee would have been seeking an increase of 218 awards at a cost of just under £8.2 million. As the new CEA scheme had been extended to include Academic GMPs, the Chairman said that the Committee was seeking a small additional increase over and above the £8.2 million. ACCEA was therefore recommending that its budget for higher CEAs and residual distinction awards should be increased by £8.5 million, to reflect the increase in the number of doctors who would be eligible for an award in the next round.
- 7.93 Commenting on ACCEA's evidence, the **Department of Health** said that in its view, we should make recommendations on the overall size of the budget for higher awards, taking account of growth in the consultant workforce and pay uplift. ACCEA should then decide the number of new awards at each level, taking account of the funding available and the number of current awards released through retirements or other reasons. The Department also said that as part of national discussions on the new CEA scheme, the Department, the BMA and the NHS Confederation had agreed that the overall level of investment should be the same as would otherwise have been devoted to the current system of distinction awards and discretionary points. The Department said that ACCEA had noted that funding would be divided between the four higher CEA levels rather than the three existing levels of distinction awards. However, the Department said again that a collective view had been reached between the Department, the BMA and the NHS Confederation that the new scheme should have these four higher levels of award, rather than the three current levels of distinction award, and on the relative value of these four awards.

- 7.94 The Department said that it inevitably followed from this and from the agreement that investment should be at the same level as would otherwise have gone towards distinction awards, that there would be on average a smaller number of awards at each of the four new levels than currently for the three levels of award. Overall, the Department said it expected there to be broadly the same number of awards as now, relative to the size of the consultant population. Taken together with the fact that the total resources for the scheme would (subject to our recommendations) grow in the same way as the resources for distinction awards would otherwise have done, the Department said that this meant that the new scheme would provide the same overall levels of recognition and reward for those consultants making the greatest contribution to the NHS. The Department commented that the rationale behind having four, rather than three, levels of awards was to enable a more graduated scheme with stronger links between local and national awards. This in turn, it said, would provide greater opportunities for consultants to get higher awards on the basis of local contributions, and more sustained incentives for high-quality performance and commitment over the course of a consultant career.
- 7.95 The **BMA** said that it was pleased that both the discretionary points and the distinctions awards scheme had been reviewed, and welcomed the emphasis on fairness and transparency in the new CEAs. However, it said it had not reached agreement on the scheme with the Health Department who had unilaterally imposed changes about which the BMA was unhappy. It was particularly concerned that the scheme would not deliver equity and transparency and there was no provision for input by the general body of consultants. The BMA said it wanted to raise with us the value of the higher awards under the new scheme. Under the distinction awards scheme, the value of awards were based upon 95 per cent (A+), 70 per cent (A) and 40 per cent (B) of the top of the consultant salary scale (currently £70,715). As the BMA expected a majority of consultants to opt to move onto the new contract, it argued that the higher CEAs (levels 9-12) should also be in the range 40 per cent to 95 per cent of the top of the new salary scale (£88,000).
- 7.96 In Wales, the BMA said that as part of the proposed new contractual arrangements, it had been agreed that there would be a new scheme of 'commitment' and CEAs to replace existing discretionary points and the distinction awards scheme. A commitment award would be granted to those reaching the top of the incremental scale and then at three-yearly intervals after that. Consultants could acquire up to eight such awards and could also apply for the higher level CEAs. The BMA said that it was still unclear how the CEA scheme in Wales would tie-in with that for England. Our support was sought to secure an equitable arrangement regarding funding for CEAs in Wales.
- 7.97 In Scotland, the BMA said there was support amongst consultants for discussion on alternatives to the distinction awards scheme and there was agreement with SEHD to begin negotiations on a replacement scheme. The BMA hoped that negotiations would be completed by April 2004. The existing discretionary points and distinction awards schemes would therefore continue in Scotland for the time being and we were asked to make recommendations on this basis. As for England, the BMA said it expected a majority of consultants to opt for the new contract, and so it considered that the top of the salary scale for the new contract in Scotland (£88,010) should be used to determine the value of distinction awards.

- 7.98 The **British Dental Association** (BDA) reported that it had carried out a survey to investigate the effect of *Shifting the Balance of Power* on the relative job demands and responsibilities of consultants in Dental Public Health. The results had shown a substantial increase in the workload of this group. We were therefore asked to recommend an increase in the allocation of discretionary points per consultant, in order that consultants in Dental Public Health could have increased access to these awards to reflect their increased workload and job complexity.
- 7.99 In supplementary evidence, the **Department of Health** said it was very surprised to see a statement in the BMA's evidence that it had not agreed the CEA scheme, since the framework for the scheme was the result of extensive negotiations with the BMA. The Department said that the broad features of the CEA scheme were set out in the June 2002 consultant contract framework document. The 'Heads of Agreement' in July 2003 had confirmed that the Department and the BMA had agreed "*the key elements of the Department's proposals for a new clinical excellence award scheme*", and that the Department and the BMA would continue to work in partnership to produce final documentation on the scheme ahead of the BMA's ballot. Following this, the Department, the BMA and the NHS Confederation had worked intensively, the Department said, to agree the full package of documentation that formed the basis for the BMA's consultation and ballot, and the framework document for the CEA scheme was an integral part of this package. The Department said that in September 2003, it had received written confirmation from the BMA that there was agreement to the document describing the full framework for the scheme and that – notwithstanding some continuing reservations – the BMA agreed that this document should form part of the overall package on which consultants were to be consulted and balloted.
- 7.100 Commenting on the BMA's proposal that the values of the higher CEAs should be in the range 40 per cent to 95 per cent of the top of the new salary scale, the Department said that the values of distinction awards had traditionally been based on 95 per cent (A+), 70 per cent (A), and 40 per cent (B) of the maximum of the consultant salary scale. However, the Department said that clinical excellence awards constituted an entirely new reward scheme, for which these old relationships were no longer relevant. The Department emphasised again that the number of levels of CEAs and the values of the awards had been agreed with the BMA, first as part of the June 2002 framework agreement, and then as part of the September 2003 framework. The Department stressed that these agreements were based on the principle that the overall level of investment in the new scheme should be the same as would otherwise have been devoted to distinction awards and discretionary points. Pegging CEAs, the Department said, to the greatly enhanced value of consultant salaries arising from the new contract would have meant an unwarranted and unaffordable increase in costs on top of the extra £250 million (in 2005-06) being invested under the contract.
- 7.101 In response to the BMA's evidence seeking our support in securing equitable funding for CEAs in Wales, the **National Assembly for Wales** commented that the scheme would be centrally funded on the same basis as the previous distinction award scheme. The Assembly said that it would ensure that consultants in Wales were not disadvantaged in relation to the number of awards made by the equivalent sub-committees in England.
- 7.102 In response to the BMA's proposal that the top of the salary scale for the new contract should be used in Scotland to determine the value of distinction awards, the **SEHD** said it did not accept this. The old salary scale would continue to exist and the SEHD said it saw no justification for increasing the value of distinction awards by more than 3.225 per cent, in line with the proposed uplift in consultants' pay. In supplementary evidence, responding to SACDA's proposals about the number of additional distinction awards for

2004-05, SEHD said that it was currently going through a prioritisation exercise across all of its budgets in response to pressures across the whole range of its spend. It said that this meant that it was not able to provide us with a definitive response on SACDA's recommended uplift at this point in time. It said that the additional money was recognised as a pressure that would be considered alongside other pressures and a decision would be made through the current prioritisation process when it was complete. It said that this exercise was likely to be completed by the end of the current financial year.

7.103 As to whether we would be expected to recommend on the size of the overall budget for higher awards and the formula for allocation, the **Department of Health** said in supplementary evidence that in previous years, the Health Departments had supported the proposals that ACDA had put to us for increases in the numbers of distinction awards, in line with the growth in consultant numbers. The Department said it had agreed with the BMA that investment in the four highest levels of CEA should be the same as would have occurred under the previous system of distinction awards. As it had set out previously, it therefore proposed that the budget for higher awards (including distinction awards that would remain in payment) should be based on the 2003-04 budget for distinction awards, increased in line with the proposed 3.225 per cent uplift in the unit value of awards and projected growth in the number of eligible doctors. The Department said that in line with this proposal, the ACCEA's evidence sought an increase in the budget for higher CEAs and residual distinction awards in England and Wales of £8.5 million. This reflected the projected increase in the number of doctors who would be eligible for an award in the next round. The Department said that it would not expect us to recommend on the number of awards to be made at each of the four levels as it considered that only ACCEA would be in a position to determine the most appropriate distribution of new awards, having regard to the growth in their budget, the number of distinction awards/CEAs already in payment at each level, and the numbers released through retirements, resignations, withdrawals and progression through the scheme.

7.104 Commenting on the BDA's request that we increase the allocation of discretionary points per consultant to give consultants in Dental Public Health increased access to these awards to reflect their increased workload and job complexity, the Department said that, as we were aware, in England, the discretionary points system had been replaced by the new CEA scheme. This was open to consultants with at least one year's service at consultant level, and the ratio of new local CEAs to eligible consultants would be a minimum of 0.35 per annum. The Department said that all levels of CEA would be made against the same criteria to reflect nationally agreed objectives. The CEAs were not intended to reward increased workload and job complexity, but rather to reward consultants who performed over and above the standard expected of a consultant in their post. The Department said that achievement would be measured within the parameters for which the consultant was employed, and would recognise service over and above the normal delivery of the consultant's job plan and contractual duties. The Department considered that the BDA's request was therefore inappropriate.

7.105 In supplementary evidence, the **BMA** said it wanted to clarify the circumstances surrounding the outcome of the BMA/Department of Health discussions on clinical excellence awards in September. It confirmed that during the Heads of Agreement discussions in July 2003, it had agreed to the principles of the proposals for the new CEA scheme. However, when finalising all of the documentation to support the new contract, it became clear that it still held significant reservations about the detail of the new CEA scheme. It said it recognised that it would be unhelpful to delay the start of the referendum on the new contract because of its concerns. It said it therefore made in

clear to the Department that whilst it was including the CEA scheme in the package of contract information being mailed to all consultants and specialist registrars in England, it would not view the CEA scheme as being agreed. It said that all of the documentation, with the exception of the CEA documentation, was printed as “an agreement between the BMA’s Central Consultants and Specialists Committee and the Department of Health for consultants in England”. It said it remained concerned that the value of discretionary points was 8.3 per cent higher than the new local clinical excellence awards. During negotiations on the new scheme, it said it was its understanding that if the value of the new CEAs was to be lower than discretionary points, the quota of awards per consultant would be uprated in compensation so that at least as much funding was available for the new scheme compared to the old scheme per Trust. It said this was not reflected in the final document, and the Department’s argument that earlier eligibility for awards outweighed the lower value of awards did not apply on a Trust by Trust basis. In Trusts where there were few new consultants, the BMA said that the funding available for local CEAs would drop in comparison with the old discretionary points system.

Comment

- 7.106 *We have been asked by the BMA to consider different issues for each country. Looking at England, we have considered the BMA’s evidence that it did not agree the new CEA scheme, its alternative proposals for determining the value of the four higher levels awards, and its concerns about the unit value of the lower level of awards. We note that the BMA did not endorse the documentation on the CEA scheme, which it sent out as part of a package of contract documentation on which consultants were balloted last autumn. However, it is our view that the scheme as set out in that documentation has been approved by consultants in their ballot, and that the scheme as described should therefore be implemented. We do not intend at this stage to re-open the details of how the scheme will operate, or how its funding envelope is to be determined. We therefore endorse and **recommend** (recommendation 20) the introduction of the new CEA scheme, as described in the documentation on which consultants were balloted last autumn. We note that the funding for the scheme will be based on the current funding for the discretionary points and distinction awards schemes, and that this will grow year on year in accordance with the ratio set out in the documentation on the scheme, the growth in the eligible consultant population and the impact of our annual pay uplift recommendation.*
- 7.107 *We note ACCEA’s observation that there will need to be a smaller base number of awards at the four higher levels than was presently the case under the distinction awards scheme. However, this is the inevitable result of the funding arrangements for the scheme. The ACCEA has also said that the funding for each national award should be calculated according to a robust formula which determines the number at each level, and that in the past, identifying this has been our role. ACCEA has also asked for the flexibility to determine the number of awards to be made at each level. We accept that the initial level of funding for the higher level awards will be determined by the current level of funding for the distinction awards scheme, the increase in the consultant population and the consequent number of additional distinction awards that would have been recommended if the old scheme had continued, and our pay uplift recommendation for 2004-05. Within this funding envelope, it will then be for ACCEA to decide how many awards at the four higher CEA levels should be awarded for the initial round of the new scheme. Only ACCEA will be in a position to judge this initially, but we would expect in future to receive their advice on the number of awards we should recommend each year, in the same way as we were advised by ACCEA’s predecessor, ACDA.*

- 7.108 *With regard to the uplift in the value of the CEAs for 2004-05, we consider that as the new scheme is being introduced as part of the consultant contract package, that the same uplift should be applied to the CEA scheme as has been agreed for the new contract. We therefore **recommend** (recommendation 21) that the value of CEAs (and distinction awards currently in payment) should be uplifted by 3.225 per cent in 2004-05.*
- 7.109 *The ACCEA has proposed that if the distinction awards scheme had still been in operation in England and Wales, the Committee would have been seeking an increase of 218 awards at a cost of just under £8.2 million to reflect the growth in the consultant population. The Committee is also seeking a small increase of £300,000 to reflect the extension of the scheme to academic GMPs. We therefore **recommend** (recommendation 22) that the initial funding baseline for higher level CEAs in England and Wales in 2004-05 should be the 2003-04 funding baseline for the distinction awards scheme, increased by £8.5 million, as recommended by ACCEA, and our pay uplift recommendation for the new consultant contract of 3.225 per cent.*
- 7.110 *With regard to Wales, the National Assembly for Wales has said that it will be centrally funding the new CEA scheme on the same basis as the previous distinction awards scheme, and that the Assembly would ensure that consultants in Wales were not disadvantaged in relation to England. We would expect to see equitable arrangements applying in both countries and would ask for evidence on this for our next review.*
- 7.111 *We would also ask the parties for their preliminary assessment of the effectiveness of the new CEA scheme once one full award round has taken place.*
- 7.112 *In Scotland, we see no case for changing the basis of the current discretionary points or distinction awards scheme in advance of the parties commencing their discussions about new arrangements. However, in order not to prejudice these forthcoming discussions and to maintain a level playing field across all three countries, we **recommend** (recommendation 23) that the value of discretionary points and distinction awards should be uplifted by 3.225 per cent in 2004-05. We note the SEHD's evidence that it is going through a prioritisation exercise across all of its budgets in response to pressure across the whole range of its spend, and that, as a consequence it is not able to provide us with a definitive response on SACDA's recommended uplift at this point in time. Since, however, we understand that those recommendations have been made in accordance with the agreed structure of the scheme, they ought in all fairness to be accepted by us without our having in some novel way to tailor our endorsement of SACDA's proposals for the number of distinction awards for 2004-05 to fit what we have only now been informed are potential internal funding concerns within the Scottish Executive. We therefore endorse and **recommend** (recommendation 24) SACDA's proposals for 24 new distinction awards at the following levels: two 'A+' awards, seven 'A' awards, and 15 'B' awards. We look forward to hearing progress of the forthcoming review of the current arrangements in Scotland for our next review.*
- 7.113 *Finally, we note the BDA's request for an increase in the allocation of discretionary points per consultant in order to enable consultants in Dental Public Health to have increased access to these awards. As we have already said, we endorse the CEA scheme as supported by consultants in their contract ballots last autumn and do not intend to re-open the detail of the scheme now. However, we would expect applications for awards from this group of specialists to be considered in the same way as applications from consultants in any other speciality, against the published criteria for the scheme.*

Clinical academic staff

- 7.114 The **Department of Health** said that the Department for Education and Skills (DfES), BMA, BDA, Universities and Colleges Employers' Association, NHS Confederation and the Department had agreed and published a set of principles for applying the new consultant contract to clinical academic staff in England. This formed part of the documentation supported by a majority of consultants in the BMA's recent ballot.
- 7.115 While this group was formally outside our remit, the **BMA** said that it had found our support extremely useful in taking forward solutions to the problems of recruitment and retention in academic medicine. It would be grateful for any assistance we could provide this year, especially in the context of the recent contractual changes, and hoped we could agree that the following important issues needed to be addressed:
- speedy development of robust mechanisms to support joint university/NHS job planning;
 - unambiguous commitment from all the relevant stakeholders to fund the contract in full (and particularly any work over the standard ten programmed activities); and
 - the protection of a cap on working hours for clinical academics.
- 7.116 The **BDA** said it welcomed the positive and supportive comments in our reports on the principle of pay parity and for incentives to ensure that sufficient doctors and dentists entered dental and medical academia. It hoped that all aspects of the new consultant contract would be fully translated across to clinical academics, including backdating to 1 April 2003, and that DfES would make provision to fully fund the new contract in England. The BDA remained concerned about the possible loss of pay parity for some clinical academics following devolution, which could have a potentially detrimental effect on recruitment and retention, and hoped we would continue to support pay parity for all clinical academics in the UK.
- 7.117 In supplementary evidence, the **Department of Health** said that in their recent ballot, over 90 per cent of clinical academics (on a turnout of 25 per cent) had voted to accept the new consultant contract.

Comment

- 7.118 *We were pleased to learn that a significant majority of clinical academic staff who voted in the recent ballot have voted in favour of the new consultant contract. We hope that the new contract will prove to be a useful aid to the recruitment and retention of this important group of staff. We also hope that any outstanding issues on which implementation of the contract may depend can be resolved quickly. Funding is obviously an important issue for the successful implementation of the contract and we hope that the parties will keep this in mind as they take forward implementation.*
- 7.119 *As we have said in previous reports, our remit does not extend to making specific recommendations for clinical academic staff, but we would nevertheless repeat our comments made in earlier reports that we support the principle of pay parity between clinical academic staff and NHS clinicians, that it is important that there are sufficient incentives for doctors and dentists to enter academic medicine or dentistry, and that clinical academic staff should be fully considered for the full range of discretionary payments to which they may be entitled. We hope that the parties will continue to bear these points in mind in ongoing work for this group.*

CHAPTER 8: STAFF AND ASSOCIATE SPECIALISTS/NON-CONSULTANT CAREER GRADES (SAS/NCCGs)

- 8.1 *From this year, we are dedicating a separate chapter to this important group of doctors and dentists. As there is not agreement yet between the parties about the generic title for this group, we have decided to adopt “staff and associate specialist/non-consultant career grade” (SAS/NCCG) for the purposes of our commentary.*
- 8.2 *We have commented in our last three reports on the need to take forward work looking at the role of these grades, their career progression and training opportunities. We have also commented on the need for any changes to the remuneration system arising from this work to be made as soon as possible as any delay would have serious consequences for the morale of this group of doctors and dentists. We are therefore pleased to note that some progress has been made since we last reported, but we are disappointed that the work is yet to be concluded, including the subsequent consideration of remuneration issues.*
- 8.3 *Against this background, several pay issues are raised for our attention this year: the Department’s ongoing review of SAS/NCCG doctors, pay comparison, optional and discretionary points, out-of-hours work and unsocial hours work, superannuation, progression from staff grade to associate specialist and job plans. The BMA also returns to the issue of staff grades on the pre-1997 contract. Finally, we are asked to consider clinical assistants and hospital practitioners. We consider these various issues below, after the summaries of the parties’ evidence.*
- 8.4 *The current payscales are as follows¹.*

Associate specialist (AS)	Staff grade (SG) (post-1997 contract)
£32,220	£29,060
£35,730	£31,440
£39,240	£33,820
£42,750	£36,200
£46,260	£38,580
£49,770	£40,960
£54,405	(£43,340)
£57,915	(£45,720)
(£60,090)	(£48,100)
(£62,265)	(£50,480)
(£64,440)	(£52,860)
(£66,615)	
(£68,790)	

¹ The first eight points of the AS payscale and the first six points of the SG payscale are incremental. The italicised figures for both ASs and SGs denote discretionary points.

Recruitment and retention

- 8.5 The **Health Departments** reported that in Great Britain in 2002, associate specialist and staff grade numbers had increased by 880 (wte), or 13.3 per cent. Non-consultant career grade (NCCG) numbers had risen an average of 11.3 per cent a year since 1997 and by 13.3 per cent between 2001 and 2002. There was no evidence of any general recruitment and retention problems in these grades. The **National Assembly for Wales** reported that NCCG numbers had risen by an average of two per cent a year since 1997 and by 9.6 per cent between 2001 and 2002. The **Scottish Executive Health Department** (SEHD) reported that associate specialist and staff grades had increased by five (wte) or 0.88 per cent in 2002.
- 8.6 In supplementary evidence, the **British Medical Association** (BMA) said that it was difficult to get accurate data about recruitment and retention as the annual census conducted by the Department of Health was not sensitive enough to count all doctors and dentists in staff grade, associate specialist, clinical assistant and non-standard posts. The BMA said it had asked the Department of Health to change the census questions so that accurate information could be captured. The Department's figures for staff doctors suggested an increase in numbers, but the BMA said that this was at the same time as the numbers of Clinical Medical Officers (CMOs) had gone down. The BMA said that there was an active regrading programme going on at the moment to convert CMOs to staff grade doctors and Senior Clinical Medical Officers to associate specialists. The BMA said that the apparent increase in numbers was not due to new posts being created.

Three-year pay offer

- 8.7 In supplementary evidence, the **Department of Health** confirmed that the ten per cent three-year pay deal had been offered to medical staff groups other than consultants. The Department said it had written to the BMA on 9 January 2003 in respect of senior doctors, inviting the BMA to agree a ten per cent three-year deal for all groups of hospital doctors, and that the BMA had declined this offer for NCCGs.
- 8.8 Commenting in supplementary evidence on the offer of a three-year ten per cent pay deal for SAS doctors, the **BMA** said that the offer was rejected as prejudicing the Review Body system, as well as creating an unjustifiable link between the pay increases for staff affected by new contracts and those for whom contract negotiations had yet to start.

Non-consultant career grade review

- 8.9 The **Department of Health** said that the implementation of *Modernising Medical Careers* would offer NCCG doctors more opportunities to undertake further training. It reiterated the Government's commitment to ensuring that NCCGs were properly valued for their contribution and provided with opportunities to achieve their potential. In July 2003, the Department said it had published for consultation *Choice and Opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors*. The consultation period had closed on 31 October 2003. The Department said its proposals sought to address NCCGs' concerns about the lack of opportunity for career development and lack of support. It proposed to align the reform of these grades closely with new training structures to remove existing difficulties about re-entering training, to provide clear pathways back into training and better support for continuing development. To support this, the Department said that the new Postgraduate Medical Education and Training Board (PMETB) legislation now allowed more of NCCGs' skills and qualifications to be assessed, recognised and used to advance careers. The consultation's proposals also reflected the work done on competency-based assessment.

- 8.10 The Department said that the consultation document had stated that “a new career structure and competencies will need new pay and terms and conditions of service...”, and more detailed work would be needed to review pay structures, including looking at the advantages of a single pay spine and terms and conditions of service. The use of job evaluation had been proposed to help the process, with barriers between the NCCG and training grade pay structures needing to be addressed. The Department said it had found the PricewaterhouseCoopers (PwC) NCCG survey undertaken on our behalf to be helpful, but did not think it was possible to draw firm conclusions from it in isolation. The Department said it also needed to address wider issues, including training and career progression, to ensure pay and reward were properly aligned with skills, competencies and responsibility.
- 8.11 The Department said that it would continue to work with the profession and once a way forward had been resolved on issues such as the development of competencies and provision of better career development, the Department would ensure that the current system of pay and reward was modernised to best support delivery of the wider objectives. It said it was essential to await the outcome of the review before considering changes to current terms and conditions. The Department said it was therefore seeking a 2.5 per cent increase in pay levels for 2004-05, but without prejudice to the outcome of the proposed wider review of pay. We were invited to endorse the Department’s proposals for reviewing pay, terms and conditions for staff grade and associate specialist doctors to take into account the new career structures proposed in *Modernising Medical Careers*.
- 8.12 The **SEHD** said it recognised that there would continue to be a role for NCCGs. It also expected significant improvement in the provisions for the professional development of these grades, in the light of the establishment of the PMETB, enabling them to pursue completion of their training and to enter the Specialist Register. The **National Assembly for Wales** said that the consultation paper issued in England had also been issued in Wales and its findings would be considered. A conversion policy from NCCG to training grade posts was to be introduced in Wales, subject to funding and approval from the Postgraduate Deanery.
- 8.13 The **NHS Confederation** said that it warmly welcomed the Department’s consultation document. It had actively supported the need to review the career structure for NCCGs and ensure that their contribution was properly valued in a coherent and coordinated fashion. The document had made clear that there would be a need to review the pay structure, and the Confederation supported that view. However, this could not take place until there was agreement about the broader issues of the role and structure of the grade. It would therefore not be appropriate for us to make changes to the NCCG pay structure at this time. The Confederation said it understood why the Department of Health was seeking an award of 2.5 per cent. However, it said it was not sure that the benefits would outweigh the divisive effect of a lower award. The Confederation recognised that there might be merit in making a single-year award because of the forthcoming pay structure review (although the timescale for this was not yet clear). It said it was therefore recommending that the general pay award for NCCG doctors should be 3.225 per cent for 2004-05. In addition, the Confederation said that if the new structure was not agreed or in the process of being agreed by the time of the next review round, an award of 3.225 per cent should be made for 2005-06. We should not recommend any other changes to the pay system.

- 8.14 The **BMA** said that it was in broad agreement with the principles set out in the Department of Health's consultation document for England on reforming these grades. It added that the SEHD was also undertaking its own review of medical careers structures in Scotland, which would include the future role of the SAS grades. The BMA's Staff and Associate Specialists Committee (SASC) was seeking to negotiate with the Health Departments on a UK-wide basis to prevent major differences in structure or terms and conditions of service developing between the nations, which could result in the migration of practitioners across borders, potentially adversely affecting patient care.
- 8.15 The BMA said it was keen for negotiations to commence as soon as possible, but was aware that this could be a lengthy business and it was therefore highly unlikely that a settlement would be reached and implemented during the coming year. However, the BMA said that negotiations must not be an excuse for preventing a high pay award in 2004 – delay was no longer tenable. It reminded us of the comment in our last report of the serious consequences for the morale of this group of doctors if there were a delay in making any necessary changes to the remuneration system in the light of the reviews taking place. Given our acknowledgement of the serious consequences, we were requested to recommend a significant pay increase for SAS doctors to take immediate effect.

Pay comparison

- 8.16 The **BMA** argued that at present, SAS doctors were seriously underpaid for the hours and work undertaken. The maximum for staff grade (SG) doctors was only £40,960 (£52,860 with full optional points) and for associate specialists (AS) was £52,860 (£68,790 with full discretionary points) compared to the basic salary for consultants of £55,455 to £71,715 (including the daytime intensity supplement). The BMA said that senior SG doctors with full optional points did not reach the basic starting salary of a consultant, nor did an AS in receipt of maximum basic pay. This pay differential increased more significantly when consultants' discretionary points, out of hours intensity supplements and distinction awards were taken into account. The intensity payments uplift awarded to consultants in November 2000 was not awarded to SAS doctors and the BMA said this should be corrected. We had noted in our last report the additional resources available for consultants in England and had asked whether a similar approach might be appropriate for this group, which the SASC strongly believed was needed. It said that SAS doctors would not fare well in comparison to the new remuneration arrangements under the proposed consultant contract.
- 8.17 The BMA said that it was also unreasonable, given their level of clinical responsibility and long working hours, that SAS doctors should be paid far less than many junior doctors, and it was an anomaly that many SAS doctors earned less than the juniors they supervised. The BMA said that the majority of juniors were currently in Band 2A (48 per cent) or Band 3 (21 per cent). SHOs in Band 2A received between £43,092 to £60,426 per annum; those in Band 3 received £47,880 to £67,140. Specialist registrars in Band 2A earned between £48,168 to £70,200; those in Band 3 between £53,520 to £78,600. The BMA said that the pay differential was particularly noticeable when considering the respective starting salaries. The BMA considered that this huge inequity must be rectified as a matter of urgency and we were asked to consider recommending this. The PwC research we commissioned in 2001 had revealed that comparisons could be made between consultants and the SAS grades. At night, the BMA said that SAS grades often supervised juniors and covered for consultants. The BMA said that this had to be recognised in remuneration, particularly as the PwC research had concluded that SAS doctors' qualifications and experience were not currently recognised or rewarded.

- 8.18 In supplementary evidence, the BMA also drew our attention to its June 2002 Survey of the careers of non-consultant career grade doctors working in the North Thames region, which showed the average annual basic salaries of the SAS group. The BMA said this needed to be considered in the light of the higher average salaries of junior hospital doctors and hospital consultants.
- 8.19 The BMA urged us to increase significantly the salary of SAS doctors in order to address the pay differential between consultants and SAS doctors, and for this to be implemented ahead of the Health Departments' review.

Optional and discretionary points

- 8.20 The BMA said that the pay differential outlined above was actually even wider as a high proportion of SAS doctors were not being awarded optional and discretionary points. This had been demonstrated by the PwC research, and the BMA said it had recently presented a survey to the Health Departments which showed that many Trusts in the UK had no procedure for awarding these points, and of those who did, a large number had failed to award points in the last year. It was most disappointing that, despite our good intentions, the full benefits of the extra point added last year had not been realised. The BMA said it wanted a national scheme with a minimum number of points awarded each year, as under the consultants' current scheme. In the absence of this and given the problems SAS doctors experienced receiving points, we were asked to recommend that all optional/discretionary points for both SGs and ASs be converted to incremental points. The BMA said that additional points should then be created for SAS doctors.
- 8.21 In supplementary evidence, the BMA drew our attention to its June 2002 Survey of the careers of non-consultant career grade doctors working in the North Thames region which highlighted that a large majority (over 60 per cent) of all ASs had not been awarded any discretionary points. Similarly, the BMA said that the majority of SGs (57 per cent of whole-time and 83 per cent of part-time) had not been awarded any optional points. In addition, the BMA said that less than four per cent of all ASs had received four discretionary points and less than eight per cent of SGs had received four optional points. The BMA also said that the survey showed that the majority of SAS doctors had 26 to 30 years of experience, and yet the majority of all such doctors did not receive any discretionary or optional points. The results of the survey regarding the awarding of discretionary points also needed to be considered against the survey's findings that 17.6 per cent of respondents had full membership of a medical Royal College, and that 25.4 per cent were fellows of a medical Royal College.
- 8.22 In supplementary evidence, the **Department of Health** said that following a request from the BMA on 20 November 2003, it had undertaken to remind NHS employers that they should have optional points schemes in place for staff grade doctors and discretionary points schemes in place for associate specialists. It said this was in response to concerns that there had not been an equitable distribution of optional and discretionary points in England. The Department commented that optional points should be awarded to staff grade doctors in line with the guidance set out in Annex D to Advance Letter (MD) 4/97, and the criteria used for awarding these points should be applied equitably by an employer. The Department said that the Advance Letter made it clear that there was no automatic entitlement to optional points, but that to "warrant payment of an optional point, staff doctors will be expected to demonstrate skills and expertise beyond what would normally be expected of a practitioner in the grade and make an above average contribution to the service". The Department said that a similar scheme was set out for associate specialists (Advance Letter (MD) 7/95), in which employers should have discretionary points schemes in place with locally agreed criteria,

but that, as with optional points, the award of discretionary points was at the employer's discretion. The Department considered that it would run entirely contrary to the original purpose of these schemes to turn optional points or discretionary points into automatic incremental points. The key issue, the Department said, was difficulty in progressing beyond the grade and this could only be resolved by a fundamental review of the non-consultant career grades structure. The Department also said it would want to ensure that the review of pay arrangements for these grades included the review of the current optional and discretionary points schemes.

Hours of work – out of hours work and unsocial hours

- 8.23 The **BMA** said that the unrewarded long and unsocial hours being worked by SAS doctors also needed to be taken into account. PwC's research had shown this, and revealed that SGs in particular were working a large number of weekend and evening sessions. The BMA said that SAS doctors undertook onerous on-call work with a disturbing number undertaking a 1 in 3, 1 in 2 or even a 1 in 1 rota. The BMA also drew our attention to its June 2002 Survey of the careers of non-consultant career grade doctors working in the North Thames region which showed the type and frequency of rotas worked by associate specialists and staff grade doctors – over 20 per cent of ASs were working a 1 in 2, 1 in 3 or 1 in 4 rota and 42 per cent were working on a consultant rota. The BMA said that PwC's research had revealed that many SAS doctors were recalled to hospital when not on-call and this was not remunerated. Current contracts made no distinction between work undertaken within or outside standard hours. This was grossly unfair – the BMA said that SAS doctors needed to be protected in the same way as hospital juniors.
- 8.24 Many SAS doctors were said to be working above the maximum 48 hours per week and the BMA said it was clear from PwC's research that the EWTD had not been implemented for many doctors, or they had opted out due to financial necessity or employer pressure. Junior doctors' pay banding supplements already provided a financial incentive to employers to use SAS doctors to cover out-of-hours work. Unless immediate action was taken, even more pressure would be placed on the SAS grades to increase their hours to cover service gaps resulting from the decrease in juniors' hours. The BMA said all doctors should be able to meet the EWTD requirements and the current perverse situation for SAS doctors must end.
- 8.25 We were asked to note all these problems and were urged to help correct them by setting a higher rate of pay for all out-of-hours work, including time on-call. The BMA said that such action was required immediately.
- 8.26 In supplementary evidence, the **Department of Health** said that it agreed with the BMA that it was essential to ensure that NCCGs did not undertake excessive levels of work as a result of the implementation of the EWTD. These doctors were already covered by the regulations in full and could not be required to work over 48 hours if they chose not to. The Department said that the normal working week for staff grade doctors was clearly set down in terms and conditions, and that all NCCGs should have job plans specifying their contractual commitments. Where there were concerns that NCCGs might be regularly working over their contracted hours, the Department said that Trusts and doctors should address this locally. At the BMA's request, the Department also said it had undertaken to remind employers of their obligations to ensure that all staff grade and associate specialist grade doctors should have an up-to-date job plan, and that the job plan should be reviewed annually. The forthcoming review of pay arrangements would also need to address out-of-hours work.

Superannuation

- 8.27 The **BMA** said that an additional financial incentive for employers to request SAS doctors to work longer hours to cover service needs was that hours worked beyond 40 per week were non-superannuable under the rules of the NHS Pension Scheme, despite the fact that these were long-term contractual arrangements. The employer made savings, but SAS doctors' pensions did not fully reflect their working income. We were asked to recommend that the full 14 per cent savings on employer superannuation contributions be passed to the doctors as additional salary. This would recognise that the doctors could not 'earn' greater than full time equivalent pension rights within the scheme, but it would compensate them on an equivalent and fair basis for each hour worked.
- 8.28 In supplementary evidence, the **Department of Health** said it was strongly opposed to the BMA's suggestion. The NHS Pension Regulations provided that basic pay was superannuable up to the maximum full-time commitment and overtime was not pensionable under the scheme. The Department stressed that the NHS Pension Scheme was open to all NHS employees, and was not limited to NCCGs, and paying the superannuation costs that an employer would normally incur for overtime work would set a precedent that would arguably apply by custom and practice to all NHS staff. The Department said that the costs would increase employers' liabilities to an already generous scheme and would lead to resources being diverted from critical services to pay for staff volunteering to work above their contractual requirement. Furthermore, the Department said it believed that the BMA's suggestion would act as a disincentive to reducing long working hours.

Regrading and job plans

- 8.29 The **BMA** said it had received an increasing number of reports throughout the UK of SGs not being upgraded to AS, despite it being clear that the SGs were working at a comparable level. Such regrading difficulties had a grossly unfair direct monetary implication. The BMA said that many employers had not yet introduced or undertaken appraisal for SAS grades, which had serious pay implications. There were also reports of increasing difficulties for SAS grades getting their non-clinical work time recognised in job plans. The PwC report had shown that a large proportion of SAS doctors were engaged in non-clinical activities, such as NHS administration and teaching. The BMA said that specific time needed to be allocated for this with recognition in job plans and contracts. It also needed to be remunerated.
- 8.30 In supplementary evidence, the BMA drew our attention to its November 2003 SASC survey of hours of work and study time, which it said showed that a large number of SAS doctors were working extensive hours and were being denied protected study time. The BMA said that these results had been shared with the Health Departments.
- 8.31 The BMA said that the problems with regrading and job plans meant SAS grades were being unfairly penalised. We were asked to take account of the financial disadvantages facing SAS doctors and to reward them appropriately for their hard work. This group, the BMA said, could not and should not have to await the outcome of the Health Departments' review and subsequent negotiations (which would be lengthy) before being properly remunerated.

- 8.32 In supplementary evidence, the **Department of Health** said that it agreed with the BMA that the job plans of NCCGs should be subject to annual review, and that non-clinical work should also be recognised in their job plans. The Department said that in the case of associate specialists, National Terms and Conditions required a job plan to set out details only of a doctor's fixed commitments, but that as a matter of good practice, all of a doctor's commitments should be included in a job plan.
- 8.33 With regard to entry to the associate specialist grade, the Department advised that there were clear criteria set out in National Terms and Conditions. The Department said it did not believe that, in the majority of cases, a doctor holding a staff grade post should simply be able to upgrade to an associate specialist post, because the duties required of such a post-holder should be more challenging. In most cases, the Department said that a doctor moving from a staff grade post to an associate specialist post should have applied successfully for an associate specialist post through the normal appointment procedures. The Department said that it would consider issues around progression for NCCGs in the forthcoming review of the grade, and that its objective would be to facilitate career progression for these doctors.

Comment

- 8.34 *The BMA's case for action on pay this round is founded on fairness and the need to restore morale. The BMA argues that SAS/NCCGs have not yet had the opportunity to renegotiate their contracts, whereas all DDRB's other main medical groups have over recent years, and SAS/NCCGs are concerned that implementation of any pay outcomes from the Department's current review are likely to be some way off yet. This group have already been waiting a number of years for the promised review to get underway in earnest, and we have considerable sympathy with the BMA's frustration. However, it seems clear that if the career structure for these grades is to be considered and developed, the Department of Health needed firstly to take forward the proposed changes to the training structure for junior doctors under Modernising Medical Careers. Progress has been made on juniors, and there has now been consultation on proposals to address the current lack of career development opportunities for SAS/NCCGs. The BMA has said it is in broad agreement with the proposed principles for reforming the grades and we welcome this as we hope it means that the parties will be able to make good progress in taking forward the next key stages of the review.*
- 8.35 *We made clear in our last report our concerns about the consequences for morale of any delay in implementing changes to the remuneration system in the light of the review. We would stress this again, and **recommend** (recommendation 25) the Health Departments to make this work a high priority. Our concerns about the time needed to carry out the review, and any subsequent pay negotiations, were made clear to the Health Departments at oral evidence. We therefore expect the Departments to report measurable and identifiable progress towards reaching an agreed outcome by the time we next hear oral evidence later this year.*
- 8.36 *In the meantime, the BMA has put a number of pay requests to us for this round. We are asked to recommend a significant pay increase, to address the pay differentials with junior doctors and consultants, to incorporate all current discretionary points into the incremental pay scales and to recommend additional discretionary points, to set a higher rate of pay for all out-of-hours work, to take account of the financial disadvantages facing SAS/NCCGs on regrading and job planning, and to recommend that the 14 per cent saving on employer superannuation for hours worked in excess of 40 per week is passed back to SAS/NCCGs as pay. In our Thirty-First Report, we took what action we could at that stage to recognise some prima facie evidence of anomalies in the levels of remuneration of SAS/NCCGs. Our recommendations for that round delivered an additional pay benefit to a significant majority*

of staff grades and associate specialists. We also made clear that we could not identify from the PwC research a clear view of how and where the pay structure should be updated and said these issues required careful examination. We also said that the whole structure within which SAS/NCCGs operated should be revisited. We considered in our last report that the Departments' view that any consideration of pay needed to follow on from the review now underway was the right approach, particularly in the light of the frustration felt amongst SAS/NCCGs about career progression opportunities, which can only be addressed through the review. We still consider this to be the right approach.

- 8.37 In the last round, we recommended that an extra discretionary point should be added to the top of the discretionary scales for associate specialists and staff grades to enable some recognition in pay of the contribution being made to service delivery by those with very high job weights. The BMA's evidence this round argues that a high proportion of SAS/NCCGs are not being awarded discretionary points. However, data from the Department of Health's Earnings Survey of Medical and Dental Staff, last carried out in August 2002, indicates that 38 per cent of staff grades and 41 per cent of associate specialists were in receipt of discretionary points. This suggests that any problems with the discretionary points schemes may be localised rather than national. By the very nature of the schemes, we would not expect to see a significant majority of SAS/NCCGs holding discretionary points, but we do expect the schemes to operate fairly across the country, since otherwise our pay recommendations would be undermined. We would therefore ask the Department of Health for further evidence for our next review that the discretionary points schemes for SAS/NCCGs are being operated effectively in Trusts across Great Britain.
- 8.38 While the SAS/NCCG review is being taken forward, we wish to facilitate the recognition of high quality service delivery by those working at the highest level amongst this group, as they do not have access to any scheme to recognise clinical excellence. We do not consider this would be contrary to the wider aims of the review at this stage. We therefore **recommend** (recommendation 26) that an extra discretionary point is added to the top of the discretionary scales for associate specialists and staff grades on the post-1997 contract. Access to the new point should be on the same basis as access to the previous five points on the discretionary scales. The detail of our recommendation is set out in Appendix A.
- 8.39 The BMA has called again this round for us to set higher rates of pay for all out-of-hours work and raised again the impact on remuneration of difficulties with career progression and job planning. We dealt with both issues in our last report and our views remain unchanged – both should be considered as part of the Health Departments' review. However, we would ask the Health Departments to take steps to ensure that employers carry out their responsibility to conduct effective job planning and appraisal for these grades.
- 8.40 We do not agree with the BMA's argument regarding superannuation, in view of the possible precedent such a recommendation would set for the NHS as a whole. We would prefer the case to be put simply in terms of the pay rate for hours worked beyond the standard contracted week, and this must be an issue for consideration by the review.
- 8.41 We have considered carefully the BMA's call for a significant pay uplift this round but, as we said earlier, we remain of the view that a full consideration of pay needs to follow on from the review now underway. A significant pay uplift must be considered in that context. However, we had hoped that both the review and the subsequent work on pay would now be nearing completion and we are disappointed to find this is not the case. Although we have made clear our expectation that completion should be in sight by the time we next hear oral evidence from the parties in autumn 2004, a conclusion by then seems unlikely. We recognise the effect this is having on the morale of this group, although recruitment and retention appears to be unaffected. We also recognise that the total earnings of some SAS/NCCGs will have benefited over the last few years from a combined effects of our pay

recommendations and the incremental payscales, but this will not be true to the same degree for those on the top point of the incremental payscales. We also note that the same ten per cent three-year pay deal which supports the new consultant contract was offered by the Department of Health to SAS/NCCGs in 2003, and that it was rejected by the BMA's Staff and Associate Specialists Committee.

- 8.42 *Taking account of all of these factors but particularly in the light of the review underway, we believe that an uplift broadly in line with current inflation is appropriate. We therefore **recommend** (recommendation 27) an increase of 2.7 per cent for 2004-05 on the national salary scales of SAS/NCCGs. In addition, we wish to recognise that those at the top point of the incremental scale have not benefited in the same way as others in recent years. Any further loss of morale amongst this group could mean a real risk of deterioration of service. We therefore **recommend** (recommendation 28) that with effect from 1 April 2004, the final incremental point for associate specialists be increased to £60,000 and for staff grades should be increased to £42,500. For staff grades, this latter recommendation should only apply to those on the post-1997 contract. We suggest that the new contract is offered afresh to those on the pre-1997 contract. The recommended payscales are set out at Appendix A.*

Staff grades on the pre-1997 contract

- 8.43 The **BMA** said that it welcomed our clarification about the intended application of the additional incremental point for SGs on pre-1997 contracts, and this had been implemented from April 2003. The Health Departments had been requested to backdate the additional point to April 2002 and a response was awaited. We were asked to support this backdating as the Health Departments had originally misinterpreted our original recommendation. The BMA said that it was also seeking the inclusion here of those who had subsequently transferred contracts, left employment, retired and the next of kin of those who had died. In supplementary evidence, the BMA said that it did not have any accurate figures, but it believed that this group of doctors was getting smaller. The BMA also said that in 1997, it was financially beneficial to stay on the old contract if doctors were doing any on-call work, as remuneration for on-call was higher.
- 8.44 In supplementary evidence, the **Department of Health** said that as the additional incremental point on the staff grade scale was implemented from April 2003, it would be inappropriate to pay backpay to April 2002. The Department requested that in future, neither further incremental, nor further optional points were recommended for the pre-1997 contract. Entry to this contract was now closed. The Department said that the parties to the collective agreement had now negotiated superior arrangements that provided a clearer contractual framework for staff grade doctors, and prevented some of the practices that had, in the past, led to staff grade doctors being asked to sign additional contracts for out-of-hours work. It would be preferable, the Department believed, to incentivise staff grade doctors on protected terms to transfer to the 1997 contract.

Comment

- 8.45 *We have considered the BMA's request for our support in seeking the backdating to 1 April 2002 of the extra incremental point we recommended for staff grades on the pre-1997 contract in our Thirty-Second Report. In oral evidence, the Department of Health told us that it had accepted the Review Body's recommendation last round and it considered that it had rectified the situation going forward from 1 April 2003. We were also told that attempting to backdate the point would be difficult. In our view, the matter was considered and dealt with in our last report and is now closed.*

8.46 *It is clear that staff grades who remain on the pre-1997 contract already have a potential pay advantage over those on the new contract, as this group can access incrementally two pay points which are discretionary points for those on the new contract. On the face of it there should be an incentive to move across to the new contract in order to access the remaining discretionary points. This incentive will be increased by our earlier recommendation (recommendation 26) to add an additional discretionary point. However, it was suggested by the BMA during oral evidence that some staff grades might have chosen to remain on the old contract because on-call work was not as well remunerated under the new contract. This highlights for us the need to consider rationalising the arrangements for the two groups, and possibly incentivising pre-1997 contract holders to move to the new contract. We therefore **recommend** (recommendation 29) that the parties consider rationalisation as part of the SAS/NCCG review.*

Clinical assistants and hospital practitioners

8.47 The **Department of Health** said that it had intended to review outstanding issues for these doctors once there had been progress on the GMS contract negotiations. It remained committed to addressing these issues and regretted that competing priorities had prevented it from taking the work forward. The Department considered that the proposed review of pay arrangements for SGs and ASs would now provide a good opportunity to look in tandem at the arrangements for Clinical Assistants (CAs) and Hospital Practitioners (HPs), and to ensure that the respective arrangements paid proper regard to the relative weight of work undertaken and the skills required. Pending the outcome of this review, the Department asked us to recommend a pay award of 2.5 per cent for these groups.

8.48 The **BMA** said that CAs who were not GMPs must have access to both an incremental pay scale and optional points. At the moment, these doctors only received £3,970 per year (or £76.34 per week) on the basis of one notional half day per week, and this was unfairly low for the work done. PwC's research had also demonstrated that CAs were working beyond their contracted session. The BMA said it anticipated that negotiations on a single pay spine would also include these doctors. However, given concern about the lengthy negotiating process, the BMA asked us to recommend the immediate introduction of an incremental pay scale and optional points. The BMA said that these doctors needed our urgent assistance and this would also make it easier to integrate them into a future single spine.

8.49 In supplementary evidence, the **Department of Health** said that it recognised there was a need to clarify arrangements for clinical assistants. It also said it had given a commitment that new arrangements for this group would be considered alongside the forthcoming review of pay arrangements for NCCGs.

Comment

8.50 *As we said in chapter 2 of the report, when commenting on GMPs working as clinical assistants and hospital practitioners, we have said in our two previous reports that a fundamental review of both clinical assistants and hospital practitioners working in acute trusts was needed and that consideration of changes to the current pay structure should follow on from a review. This remains our view and we again would urge the Department of Health to take this work forward speedily. The use of clinical assistants and hospital practitioners also requires the Health Departments to make a judgement about relative priorities for the resources deployed in primary and secondary care. Any significant decisions about pay should be taken in the light of the policy decision about the need to divert primary care resources to support secondary care services. As GMPs are a key component of the clinical assistant group as a whole, resolution of the pay issues affecting clinical assistants as*

a whole will depend firstly on the Departments' decision about GMPs. We would note here that the equivalent rate for a notional half day per week, on which the current annual rate for clinical assistants is calculated, does seem low and we would ask the review to consider carefully the rate of payment for this work, in the light of the Departments' decision about deploying resources.

- 8.51 *We would stress again that we hope the Department of Health will now make measurable and identifiable progress in looking at clinical assistants as a group as part of its wider review of SAS/NCCGs. We would expect to receive evidence to this effect for the next round.*

APPENDIX A

DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: RECOMMENDED SALARY SCALES

The salary scales that we recommend for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* that of equivalent whole-time staff.

A. Hospital medical and dental, public health medicine and dental public health staff

	Current scales £	Recommended scales payable from 1 April 2004 £
	<i>(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
House officer	19,185	19,703
	20,420	20,972
	21,655	22,240
Senior house officer	23,940	24,587
	25,545	26,235
	27,150	27,884
	28,755	29,532
	30,360	31,180
	31,965 ¹	32,829 ¹
33,570 ¹	34,477 ¹	
Registrar	26,760	27,483
	28,115	28,875
	29,470	30,266
	30,825	31,658
	32,460	33,337
Senior registrar	30,825	31,658
	32,460	33,337
	34,095	35,016
	35,730	36,695
	37,365	38,374
	39,000	40,053
		41,733 ²

¹ To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21, and see paragraph 6.46 of the Thirty-First Report.

² New incremental point, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of this report.

	Current scales £	Recommended scales payable from 1 April 2004 £
Specialist registrar ³	26,760	27,483
	28,115	28,875
	29,470	30,266
	30,825	31,658
	32,460	33,337
	34,095	35,016
	35,730	36,695
	37,365 ⁴	38,374 ⁴
	39,000 ⁴	40,053 ⁴
		41,733 ⁵
Consultant (pre-2003 contract)	54,340	55,699
	58,295	59,753
	62,250	63,807
	66,205	67,861
	70,715	72,483
<i>Discretionary points⁶</i>		<i>Value</i>
	2,835	2,927
	5,670	5,854
	8,505	8,781
	11,340	11,708
	14,175	14,635
	17,010	17,562
	19,845	20,489
	22,680	23,416
Consultant (post-2003 contract, England and Scotland) ⁷	65,035	67,133
	67,100	69,264
	69,165	71,396
	71,230	73,528
	73,295	75,659
	78,200	80,722
	83,105	85,786
	88,010	90,849
<i>Clinical excellence awards⁸</i>		<i>Value</i>
	2,617	2,702
	5,234	5,404
	7,851	8,106
	10,468	10,808
	13,085	13,510
	15,702	16,212
	20,936	21,616
	26,170	27,020
	31,404	32,424

³ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁴ To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eight Report, paragraph 3.21.

⁵ New incremental point, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of this report.

⁶ Eligibility for discretionary points is after five years' service as a consultant.

⁷ These are pay thresholds and transitional arrangements apply.

⁸ Local level CEAs. Eligibility for CEAs is after one years' service as a consultant.

	Current scales £	Recommended scales payable from 1 April 2004 £
Consultant (post-2003 contract, Wales) ⁹	63,000 65,035 68,440 72,395 76,910 79,485 ¹⁰ 82,065 ¹¹	65,032 67,133 70,648 74,730 79,391 82,049 ¹⁰ 84,712 ¹¹
<i>Commitment awards</i> ¹²		<i>Value</i>
	2,835 5,670 8,505 11,340 14,175 17,010 19,845 22,680	2,927 5,854 8,781 11,708 14,635 17,562 20,489 23,416
Associate specialist	32,220 35,730 39,240 42,750 46,260 49,770 54,405 57,915	33,090 36,695 40,300 43,905 47,510 51,114 55,874 60,000 ¹³
<i>Discretionary points</i>		<i>Notional scale</i>
	60,090 62,265 64,440 66,615 68,790	61,713 63,947 66,180 68,414 70,648 72,882 ¹⁴
Staff grade practitioner (pre-1997 contract, MH01)	29,060 31,440 33,820 36,200 38,580 40,960 43,340 45,720	29,845 32,289 34,734 37,178 39,622 42,066 44,511 46,955

⁹ Effective from 1 December 2003.

¹⁰ Effective from 1 December 2004.

¹¹ Effective from 1 December 2005.

¹² Awarded every three years once the maximum on the payscale is reached.

¹³ Incremental point increased, see paragraph 8.42 in this report.

¹⁴ New discretionary point, see paragraph 8.38 in this report.

	Current scales £	Recommended scales payable from 1 April 2004 £
Staff grade practitioner (post-1997 contract, MH03/5)	29,060	29,845
	31,440	32,289
	33,820	34,734
	36,200	37,178
	38,580	39,622
	40,960	42,500 ¹⁵
<i>Discretionary points¹⁶</i>		<i>Notional scale</i>
	43,340	44,511
	45,720	46,955
	48,100	49,399
	50,480	51,843
	52,860	54,288
		56,732 ¹⁷
		<i>(annual rates on the basis of a notional half day per week)</i>
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	3,970	4,078
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	3,885	3,990
	4,110	4,221
	4,335	4,453
	4,560	4,684
	4,785	4,915
	5,010	5,146
	5,235	5,377

Details of the supplements payable to public health medicine staff are set out in Part II of this Appendix.

B. Community health staff

*(salary scales excluding earnings from
additional sources, such as out-of-hours
payments for training grades)*

Clinical medical officer	27,800	28,551
	29,355	30,148
	30,910	31,745
	32,465	33,342
	34,020	34,939
	35,575	36,536
	37,130	38,133
	38,685	39,730

¹⁵ Incremental point increased, see paragraph 8.42 in this report.

¹⁶ See Twenty-Seventh Report, paragraph 2.34.

¹⁷ New discretionary point, see paragraph 8.38 in this report.

	Current scales £	Recommended scales payable from 1 April 2004 £
Senior clinical medical officer	39,665	40,736
	42,135	43,273
	44,605	45,810
	47,075	48,347
	49,545	50,883
	52,015	53,420
	54,485	55,957
	56,955	58,493

C. Salaried primary dental care staff¹⁸

	<i>(salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
Band 1: Community dental officer	29,365	30,313
	31,815	32,842
	34,265	35,371
	36,715	37,900
	39,165	40,429
	41,615	42,958
	44,065 ¹⁹	45,487 ¹⁹
	46,515 ¹⁹	48,016 ¹⁹
Band 2: Senior dental officer	42,355	43,721
	45,780	47,257
	49,205	50,792
	52,630	54,328
	56,055	57,863
	56,810 ²⁰	58,643 ²⁰
	57,565 ²⁰	59,422 ²⁰
Band 3: Assistant clinical director	56,585	58,410
	57,475	59,329
	58,365	60,248
	59,255	61,166
	60,145 ²⁰	62,085 ²⁰
	61,035 ²⁰	63,004 ²⁰
Band 3: Clinical director	56,585	58,410
	57,475	59,329
	58,365	60,248
	59,255	61,166
	60,145	62,085
	61,035	63,004
	61,925	63,923
	62,830	64,857
	63,720 ²⁰	65,775 ²⁰
	64,610 ²⁰	66,694 ²⁰

¹⁸ These payscales also apply to salaried dentists working in Personal Dental Services.

¹⁹ Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First Report. See also Twenty-Eighth Report, paragraph 8.9 (community dental officers) and Twenty-Ninth Report, paragraph 7.61 (salaried general dental practitioners).

²⁰ Performance based increment, see paragraphs 4.21 and 4.38 of the Thirty-First Report. See also Thirtieth Report, paragraph 8.15.

	Current scales £	Recommended scales payable from 1 April 2004 £
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	49,585 52,725 55,865 59,005 62,830 63,720 ²¹ 64,610 ²¹	51,185 54,426 57,667 60,908 64,857 65,775 ²¹ 66,694 ²¹
Part-time dental surgeon:	<i>Sessional fee (per hour)</i>	
Dental surgeon	24.35	25.14
Dental surgeon holding higher registrable qualifications	32.30	33.35
Dental surgeon employed as a consultant	40.25	41.55

Details of the supplements payable to community dental staff are set out in Part II of this Appendix.

²¹ Performance based increment, see paragraph 4.48 of the Thirty-First Report.

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2004. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The annual values of distinction awards for consultants¹ should be increased as follows.

B award: from £28,290 to £29,203

A award: from £49,505 to £51,102

A plus award: from £67,180 to £69,347

3. The annual values of higher clinical excellence awards for consultants and academic GMPs should be increased as follows.

Bronze (Level 9): from £31,404 to £32,424

Silver (Level 10): from £41,290 to £42,622

Gold (Level 11): from £51,613 to £53,278

Platinum (Level 12): from £67,097 to £69,261

4. The funding for residual distinction awards and higher clinical excellence awards should be increased by £8.5 million for England and Wales. In Scotland, the number of A plus awards should be increased from 39 to 41, the number of A awards from 131 to 138, and the number of B awards from 285 to 300.

5. The annual values of intensity payments should be increased to the following amounts:

Daytime supplement: from £1,115 to £1,143

Out-of-hours supplement (England and Scotland) (Wales)

Band 1: from £840 to £861 from £1,920 to £1,982

Band 2: from £1,675 to £1,717 from £3,840 to £3,964

Band 3: from £2,505 to £2,568 from £5,760 to £5,946

¹ For 2004-05 applies to existing consultants currently in receipt of a distinction award in England and Wales and to eligible consultants in Scotland.

6. Under the agreement reached between the Health Departments and the BMA on the new contract for doctors and dentists in training, the following non-pensionable multipliers apply to the basic pay of whole-time doctors and dentists in training grades (and flexible trainees working 40 hours or more a week or in New Deal non-compliant posts):

	December 2002 onwards²
Band 3	2.00
Band 2A	1.80
Band 2B	1.50
Band 1A	1.50
Band 1B	1.40
Band 1C	1.20

7. Under the new contract agreed by the parties, 1.0 represents the basic salary (shown in Part I of this Appendix) and figures above 1.0 represent the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary.
8. Under the new contract agreed by the parties, the following multipliers will apply to the basic pay of flexible trainees working less than 40 hours of actual work per week:

	December 2000 onwards
Band FA	1.25
Band FB	1.05
Band FC	*

* Flexible trainees with no duty outside the period 8 a.m. to 7 p.m. Monday to Friday will be paid according to the following formula: (hours of duty/40) x basic pay.

9. The fee for domiciliary consultations should be increased from £70.90 to £73.19 a visit. Additional fees should be increased *pro rata*.

² See paragraph 6.41 of this report.

10. Weekly and sessional rates for locum appointments in the hospital service should be increased as follows:

Consultant appointment ³	from £1,228.15 to £1,258.95 a week; from £111.65 to £114.45 a notional half day
Associate specialist, senior hospital medical or dental officer appointment	from £853.52 to £876.59 a week; from £77.59 to £79.69 a notional half day
Specialist registrar LAS appointment ⁴	from £622.52 a week to £655.60; from £15.56 to £16.39 per standard hour
Senior house officer appointment	from £551.47 a week to £566.80; from £13.79 to £14.17 per standard hour
House officer appointment	from £391.62 a week to £402.40; from £9.79 to £10.06 per standard hour
Hospital practitioner appointment	from £86.70 to £89.05 a notional half day
Staff grade practitioner appointment	from £694.00 to £712.80 a week; from £69.40 to £71.28 a session
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)	from £76.80 to £78.88 a notional half day

11. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

Ophthalmic medical practitioners

12. The ophthalmic medical practitioners' gross fee for sight testing should be negotiated between the parties.

³ The rates are for those appointments made under the pre-2003 consultant contract. For locum rates under the post-2003 consultant contract, refer to Schedule 22 of the new contract's Terms and Conditions of Service. Where a consultant takes a locum appointment after retirement, and provided the consultant was remunerated at the scale maximum, the rates applicable instead should be increased as follows:

from £1,360.15 to £1,394.25 a week;
from £123.65 to £126.75 a notional half day.

⁴ The specialist registrar LAS appointment rates have been adjusted to take account of the effect of the additional incremental point added to the end of the scale, see paragraph 6.61 of this report.

Doctors in public health medicine

13. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows⁵:

	Current range of supplements £	Recommended range or supplements payable from 1 April 2004 £
Island Health Boards: Band E (under 50,000 population)	1,525 – 3,025	1,575 – 3,123
District director of public health (director of public health in Scotland/Wales):		
Band D (District of 50,000 – 249,999 population)	3,025 – 6,050 (Bar); 7,565	3,123 – 6,246 (Bar); 7,809
Band C (District of 250,000 – 449,999 population)	3,795 – 7,565 (Bar); 9,090	3,918 – 7,809 (Bar); 9,384
Band B (District of 450,000 and over population)	4,540 – 9,090 (Bar); 11,725	4,687 – 9,384 (Bar); 12,104
Regional director of public health: Band A:	11,725 – 17,020	12,104 – 17,569

14. From 1 December 2000, no supplement will be payable to trainees in public health medicine or dental public health for out-of-hours commitments. Under the new pay system, trainees will receive the banding supplement applicable to their hours and working arrangements.

General medical practitioners

15. The supplement payable to GMP registrars for out-of-hours duties is 65 per cent⁶ of basic salary for 2004-05.
16. The salary range for salaried GMPs⁷ employed by Primary Care Organisations should be £47,710 to £72,478 for 2004-05.

General dental practitioners

17. The gross fee for each item of service and capitation payment should be increased by 2.9 per cent from 1 April 2004.
18. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £102.20 to £105.17.
19. The sessional fee for part-time salaried dentists working six 3-hour sessions a week or less in a health centre should be increased from £72.35 to £74.45.

⁵ Population size is not the sole determinant for placing posts within a particular band.

⁶ See paragraph 2.33 of this report.

⁷ See paragraph 2.19 of this report.

20. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review should be increased from £55.75 to £57.37.
21. The quarterly payments under the Commitment Payments scheme⁸ should be increased as follows:
- | | |
|------------------|-------------------------------|
| Level 1 payment | from £36 to £38 a quarter |
| Level 2 payment | from £314 to £324 a quarter |
| Level 3 payment | from £407 to £419 a quarter |
| Level 4 payment | from £488 to £503 a quarter |
| Level 5 payment | from £570 to £587 a quarter |
| Level 6 payment | from £650 to £669 a quarter |
| Level 7 payment | from £732 to £754 a quarter |
| Level 8 payment | from £814 to £838 a quarter |
| Level 9 payment | from £895 to £921 a quarter |
| Level 10 payment | from £975 to £1,004 a quarter |

Community health and community dental staff

22. The teaching supplement for assistant clinical directors in the CDS should be increased from £2,090 to £2,158 a year.
23. The teaching supplement payable to clinical directors in the CDS should be increased from £2,360 to £2,437 a year.
24. The supplement for clinical directors covering two districts should be increased from £1,525 to £1,575 a year and the supplement for those covering three or more districts should be increased from £2,435 to £2,514 a year.
25. The allowance for dental officers acting as trainers should be increased from £1,670 to £1,724 a year.
26. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

⁸ See paragraph 3.51 of this report.

APPENDIX B

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE^{1,2} IN GREAT BRITAIN

	2001		2002		Percentage change	
	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount
Hospital medical and dental staff^{3,4}						
Consultants	26,680	29,550	28,560	31,070	7.0%	5.1%
Associate specialists	1,680	1,940	1,860	2,100	10.3%	8.4%
Staff grade	4,860	5,800	5,560	6,110	14.6%	5.2%
Registrar group	14,140	14,810	14,870	15,680	5.2%	5.9%
Senior house officers	18,890	19,110	20,420	20,670	8.1%	8.2%
House officers	4,620	4,630	5,000	5,030	8.3%	8.5%
Hospital practitioners	240	1,130	270	1,190	11.1%	5.0%
Clinical assistants	1,810	6,140	1,520	5,500	-16.1%	-10.3%
Other	0	0	0	10	270.0%	400.0%
Total	72,920	83,110	78,070	87,340	7.1%	5.1%
Public health and community medical staff³						
Regional and district directors	110	110	190	190	74.9%	76.4%
Consultants ⁵	670	810	530	650	-21.4%	-19.5%
Registrar group	300	320	260	280	-14.1%	-12.9%
Senior house officers	30	30	30	30	-7.7%	-9.1%
Senior clinical medical officers	500	710	470	670	-5.6%	-5.3%
Clinical medical officers	320	650	270	530	-16.3%	-18.0%
Other medical staff ⁵	160	460	150	400	-5.9%	-14.7%
Total	2,100	3,100	1,900	2,760	-9.4%	-11.0%
Community dental staff³						
Regional and district dental officers/clinical director ⁵	60	70	80	90	34.5%	26.8%
Assistant district dental officers/clinical director	30	30	50	50	71.7%	67.7%
Consultants	50	70	50	70	7.0%	9.1%
Senior dental officers	410	510	410	520	0.7%	1.0%
Dental officers	720	950	780	1,070	7.9%	12.5%
Other dental staff ⁵	70	100	40	60	-40.7%	-38.4%
Total	1,340	1,730	1,410	1,860	5.8%	7.6%

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE^{1,2} IN GREAT BRITAIN (*continued*)

	2001		2002		Percentage change	
	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount	Whole-time equivalents	Headcount
General practitioners						
General medical practitioners: ⁶	34,790	38,160	35,100	38,650	0.9%	1.3%
Unrestricted Principals and Equivalents	31,130	33,380	31,150	33,580	0.1%	0.6%
General Medical Services						
Unrestricted Principals ⁵	27,500	29,480	24,900	26,790	-9.5%	-9.1%
Personal Medical Services GPs	3,640	3,910	6,260	6,790	72.1%	73.8%
Restricted principals	100	100	80	90	-13.6%	-9.8%
Assistants	380	530	350	500	-5.9%	-6.9%
GMS GP registrars	1,890	1,960	1,800	1,860	-4.8%	-4.9%
PMS GP registrars	310	320	510	530	62.9%	63.4%
Associates	50	50	40	40	-10.2%	-10.2%
GP retainers ⁷	630	1,410	630	1,370	0.1%	-2.6%
Salaried doctors (para 52 SFA)	120	160	110	130	-9.9%	-20.6%
Personal Medical Services other	180	250	420	560	129.4%	121.9%
General dental practitioners: ³	-	22,080	-	22,390	-	1.4%
principals	-	19,320	-	19,340	-	0.1%
assistants and vocational practitioners	-	2,140	-	2,200	-	2.8%
Personal Dental Services ⁸	-	470	-	660	-	40.5%
salaried dentists ⁹	-	160	-	200	-	28.4%
Ophthalmic medical practitioners ^{10,11}	-	750	-	670	-	-10.16%
Total	-	61,000	-	61,720	-	1.2%
Total – NHS doctors and dentists	-	148,930	-	153,670	-	3.2%

¹ The table contains whole-time equivalent (WTE) and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

² Figures have been rounded, but percentage changes have been calculated from unrounded figures.

³ At 30 September.

⁴ Figures include hospital dental staff – in 2001 there were a total of 2,719 (1,816 WTE) hospital dental staff compared with 2,764 (1,944 WTE) in 2002.

⁵ Data for 2001 have been revised.

⁶ At 30 September in 2001 and 2002. WTE data has been estimated using the results from the 1992-93 GMP Workload Survey.

⁷ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.

⁸ In 2001 and 2002, a further 240 and 341 dentists respectively worked in Personal Dental Services but also had a General Dental Services contract. Most of these would appear in the general dental practitioner principals row. These are excluded from Personal Dental Services figures to avoid double counting.

⁹ The figure for England for 2002 is on a different basis to that supplied in 2001, and therefore 2001 and 2002 data are strictly not comparable.

¹⁰ At end-December for England and Wales and at end-March for Scotland.

¹¹ Until 2001, practitioners contracted with more than one health board were counted under each contract in Scotland.

APPENDIX C

THE 2003-04 SETTLEMENT

In our Thirty-Second Report (and its supplement) we put forward recommendations on the level of remuneration we considered appropriate for doctors and dentists in the NHS as at 1 April 2003. Our main recommendations were:

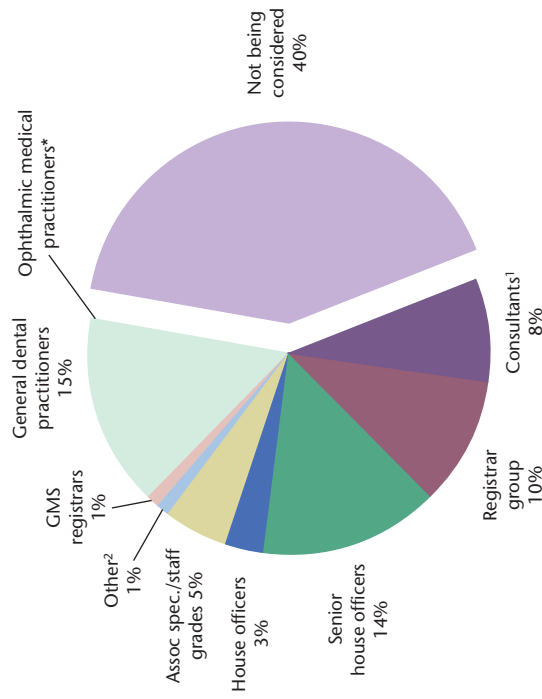
- an increase of 3.225 per cent for hospital, public health and community health doctors and dentists; and
- an increase of 3.225 per cent on gross fees for general dental practitioners.

The Government accepted in full our recommendations relating to 2003-04.

APPENDIX D

DDRB STAFF GROUPS UNDER CONSIDERATION FOR 2004-05

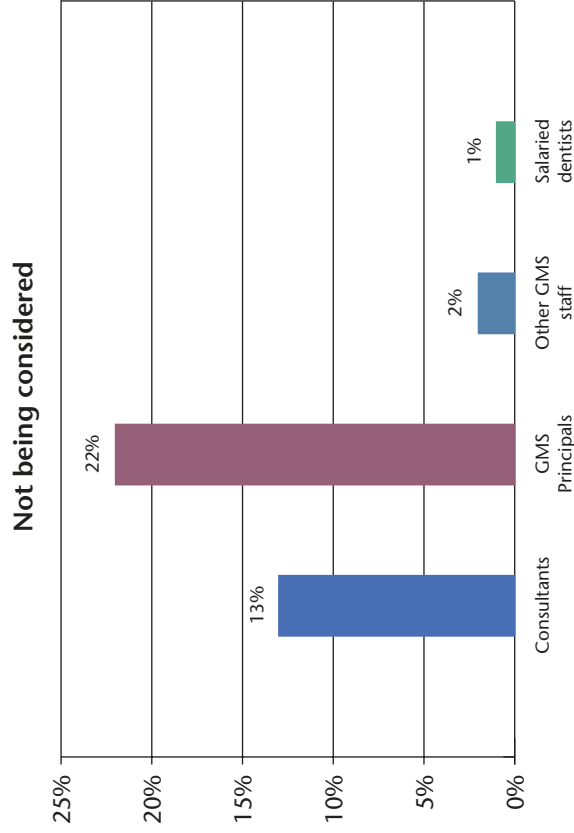
Total: 153,670 headcount, Great Britain



*less than 0.5 of a percentage point

1. For England and Scotland, based on the proportions in ballots voting against new contracts. For Wales, all consultants will adopt the new contract.

2. Hospital practitioners, Clinical Assistants, Other medical staff.



APPENDIX E

THE POLICY FRAMEWORK

1. The evidence we have received from the three **Health Departments** was set in the context of the following policy documents:
 - The *NHS Plan*¹ and *HR in the NHS Plan*² covering England;
 - *Our National Health, A Plan for Action, A Plan for Change*³, *Working for Health, the Workforce Development Action Plan for Scotland*⁴, and *A Partnership for a Better Scotland: Partnership Agreement*⁵ covering Scotland; and
 - *Improving Health in Wales – A Plan for the NHS with its partners*⁶ and *Delivering for Patients*⁷ in Wales.

2. The objective of the *NHS Plan* was to modernise the NHS in England through a combination of investment and reform. It committed the Government to increases in key staff groups over the period to 2004 alongside a range of Human Resource (HR) initiatives designed to complement the increases in numbers and improve working lives. The key targets in the *NHS Plan* affecting our remit groups were for:
 - 1,000 more medical school places;
 - 1,000 more specialist registrars;
 - 7,500 more consultants; and
 - 2,000 more general medical practitioners.

3. By 2008, the **Department of Health** expected the NHS to have net increases of 15,000 doctors (consultants and GMPs) over the September 2001 baseline. The HR initiatives in the *NHS Plan* have now been strengthened by *HR in the NHS Plan* which outlined a five-year strategy aimed at delivering increased numbers of staff with jobs designed around the needs of patients. The HR initiatives flowing from this strategy are discussed in chapter 1.

¹ *The NHS Plan* published by the Department of Health on 27 July 2000.

² *HR in the NHS Plan* published by the Department of Health in July 2002.

³ *Our National Health, A Plan for Action, A Plan for Change* published by Scottish Executive on 14 December 2000.

⁴ *Working for Health, the Workforce Development Action Plan for Scotland* published in August 2002.

⁵ *A Partnership For A Better Scotland: Partnership Agreement*, May 2003, produced by the Labour/Liberal Democrat coalition following the Scottish Parliament elections in May 2003.

⁶ *Improving Health in Wales – A Plan for the NHS with its partners* published by the National Assembly for Wales on 2 February 2001.

⁷ *Delivering for Patients*, the Human Resources Strategy for NHS Wales launched in June 2000.

4. In Scotland, *Our National Health, A Plan for Action, A Plan for Change*, set out the **Scottish Executive Health Department's** (SEHD's) long-term plans for improving Scotland's health. These focused on a more patient-centred approach and lasting investment in Scotland's health workforce. *Working for Health, the Workforce Development Action Plan for Scotland* was published in August 2002 setting out the SEHD's proposals for better workforce planning and development. Both policies emphasised the need to integrate the planning of services with the planning of the workforce needed to support them, and called for multidisciplinary development of the workforce to support service delivery.
5. *A Partnership for a Better Scotland: Partnership Agreement* set out a number of targets and commitments relating to the medical and dental workforce, including: the aim of increasing the number of consultants in the NHS by 600 by 2006, and continuing to build on that thereafter; further measures to attract and retain GMPs; and the options for addressing the shortfall in the number of dentists in some areas of Scotland. The need for further measures for the medical and dental workforce would be informed by work underway to improve workforce development and workforce planning.
6. The SEHD confirmed that its evidence complemented that of the other Health Departments and it endorsed evidence representing a Great Britain-wide position. The differing context of health service delivery in Scotland was outlined – geography and demography, poorer health record, but a relatively more stable workforce.
7. The **National Assembly for Wales** said that its evidence outlined any policy differences in the NHS in Wales, otherwise its evidence complemented that of the other Health Departments. The Assembly described how planned changes to streamline management arrangements within the NHS in Wales would help to achieve the aims set out in *Improving Health in Wales – A Plan for the NHS with its partners*, launched in 2001, whose key objective was to deliver patient-centred care of the highest quality for the people of Wales. The Assembly's new workforce planning process was based on need, taking into account national and local strategies, policies and initiatives, rather than affordability. Based on the 2001 Workforce Planning process, the Assembly planned to have almost 9,000 more professional staff in NHS Wales by 2010, including 700 more hospital consultants and GMPs. A range of HR initiatives were being taken forward through the HR Strategy for NHS Wales, *Delivering for Patients*, and are described in chapter 1.
8. The **BMA** confirmed that, unless otherwise stated, its evidence covered the United Kingdom⁸ as a whole and that, where appropriate, issues affecting the constituent countries were dealt with separately.

⁸ DDRB's remit extends to Great Britain.

APPENDIX F

JOINT LETTER FROM THE BRITISH MEDICAL ASSOCIATION, NHS CONFEDERATION AND THE DEPARTMENT OF HEALTH ABOUT PROGRESS ON THE NEW GMS CONTRACT



Room 3E54
Quarry House
Quarry Hill
Leeds
LS2 7UE
Tel: 0113 2546288
Fax: 0113 2545383

8 January 2004

Michael Blair QC
Chair – DDRB
Office of Manpower Economics
Oxford House
76 Oxford Street
London
W1N 9FD

Dear Michael

Review Body on Doctors' and Dentists' Remuneration: General Medical Practitioners and the Thirty-Second Review

In our joint letter of 8 September 2003 we updated you on progress in the wake of the result of the ballot, in which GPs voted to accept the new GMS contract, and invited the DDRB's formal endorsement, which your reply provided.

We are now in a position to provide a further update. Following a period of intensive work involving all the parties, drafts of the contract documentation have now been published on the Department of Health's website (www.doh.gov.uk/gmscontract/implementation.htm).

They consist of:

- draft GMS contract regulations
- draft standard contract with explanatory notes for PCTs
- draft Statement of Financial Entitlement (SFE)
- guidance: "Delivering Investment in General Practice"

The documents are self-explanatory and we are providing you with hard copies. The Health Departments in Scotland, Wales and Northern Ireland will publish versions of these documents within the next few weeks reflecting the different legislative and implementation structures in each country.

We now invite the DDRB to note the continuing progress being made to facilitate implementation of the new GMS contract throughout the UK from 1 April 2004.

Yours sincerely

John Chisholm
Chairman
General Practitioners Committee
British Medical Association

Mike Farrar
Chairman
New GMS Contract
Negotiating Team
NHS Confederation

Ian Dodge
Head
General Medical Services
Department of Health

Copy: Maureen Foggo
Richie Malloch
Derek Fishwick
Ivan McMaster

APPENDIX G

EXECUTIVE SUMMARY OF THE DENTISTS' COMMITMENT PAYMENTS SCHEME REPORT, BMRB SOCIAL RESEARCH

Executive Summary

The Commitment Payment Scheme (CPS) was introduced in 2000 following a recommendation from the Review Body on Doctors' and Dentists' Remuneration (DDRB). The Scheme operates on a tiered system and is based on gross annual income in respect of NHS work carried out, as well as on the length of dentists' service within the GDS.

The 31st annual report produced by the DDRB, called for the British Dental Association (BDA) and the Department of Health (DoH) to carry out research which explored the effectiveness of the scheme. However, as the research was unable to look at General Dental Service (GDS) commitment in relation to the CPS in isolation, it was felt to have limitations. Consequentially, the DDRB felt further research into the CPS was required. To meet this end, **BMRB Social Research** was commissioned by OME, on behalf of the DDRB, to carry out a qualitative study that explored dentists' views of the CPS.

The main drivers – both positive and negative, affecting commitment to the GDS

Commitment to working within the GDS varied among respondents, with some seeing themselves as committed and others not. Commitment was not generally thought to be related to the level of CP received, nor to the percentage of NHS work being carried out. Rather, commitment to the NHS and dentists' views of it were thought to be affected by other factors, such as by age, the type of area they worked in, the responsibility they felt to patients, and their ideological attachment to the NHS.

Respondents highlighted a range of positive aspects of working within the GDS. For example, they liked the principle of offering affordable treatment to all; they felt it offered a good salary; a secure lifestyle; a ready-made list of patients; a range of different patients; and some also felt NHS patients were less demanding and more appreciative than some private ones.

Despite this, a number of more **negative issues** were mentioned by dentists from across the sample. The main problems highlighted by respondents related to: the item-of-service feescale system – which they perceived as inadequate to cover the cost of treatments; increasing patient demands; the level of administration and regulations associated with performing their role; and the uncertainty surrounding the future of NHS dentistry.

A number of factors were thought to influence dentists' decisions regarding either remaining in or moving away from the NHS. These included: the age of the dentist; the type of practice or area they worked in; their moral or ethical attachment to the GDS; and the contract changes expected to occur with Options for Change or Routes to Reform.

Views on the Commitment Payment Scheme and suggested improvements

Although some dentists' held the opinion that it would be 'misguided' to re-design the Commitment Payment Scheme, unless it was to be completely overhauled, as they believed it failed to respond to the problems experienced by dentists. Others highlighted a number of ways in which they believed the CPS could be improved.

Although respondents had generally heard of the Commitment Payment Scheme as a result of seeing it in their schedule, knowledge regarding the details of the scheme was minimal. For the most part, it was felt that a general increase in awareness and knowledge of the scheme would be useful.

Mixed views were expressed regarding the eligibility criteria. While respondents tended to accept the calculation based on gross income as 'fair', some issues were raised regarding the five year rule which some felt was too long and would discriminate against younger dentists and women who had taken career breaks. Some respondents thought the five year eligibility criteria should be reduced to include either all dentists or those who had been contracted to the NHS for two or three years.

Some issues were also raised regarding the payment banding system. Aside from the levels being seen as too low overall, some dentists highlighted other issues, including:

- The disparity between the payment received in band 1 compared to other bands;
- The fact that top-ups were not made available to those in band 1; and also
- The level of gross income required to reach the higher bands was seen as too high. Some respondents thought this could negatively impact on the quality of dentistry carried out, as well as on the health of the dentist. Moreover, some felt this was encouraging a 'drill and fill' culture, rather than preventative dentistry.

Views on how effective Commitment Payments are at retaining GDPs in the GDS

Dentists did not feel that the payment had any real impact on either their views or behaviour regarding commitment to the GDS. They did not believe it would retain them in the GDS as the perceived advantages of working in private dentistry (in terms of income, quality of working life and the quality of service that could be offered to patients) were not matched by the payments offered under the Commitment Payment Scheme.

Not only were payment levels seen as being too low, but some also felt the scheme 'missed the point', as it focused on income rather than on other issues, such as time pressure, quality of dentistry and workload.

The effect Commitment Payments had on GDPs' motivation to practice in the GDS

Although respondents tended not to believe the scheme would have any impact on their retention or commitment to the NHS, receiving an additional cash sum was welcomed by all respondents – particularly by some Associates and those in the higher bands. The payment was seen as a 'reward' and some felt this payment motivated them in their role.

Some suggestions for increasing motivation among GDPs were made by dentists. Within the existing structure, it was felt that a significant increase in the fee-scale (at least 10%) would positively impact on motivation, as would the re-introduction of specific treatments, such as gold crowns. It was also thought that motivation could be increased by introducing an alternative remuneration system, such as a core service, salaried dentistry, or a system akin to General Medical Practice.

It should also be noted, that although the views expressed by the respondents regarding the impact of the CPS did not differ according to the sample characteristics, such as age, gender or the level of the Commitment Payment received. Some respondents felt the system could be more effectively aimed at certain types of dentists, namely those who were older (especially those nearing retirement), younger newly qualified dentists, those working in more deprived areas, and also those with a strong ethical and moral attachment to the NHS.

APPENDIX H

RESPONSES TO DENTISTS' COMMITMENT PAYMENTS SCHEME REPORT

Department of Health

Thank you for the research report on Commitment Payments.

The report does not indicate any need for you to do further research. Commitment Payments do not seem to be an important issue for dentists and have little effect on working patterns, in particular on the choice between NHS and private work. There is some ignorance of the Scheme. For assistants, this may be because the Scheme was only extended to them last April. Some of the facts mentioned about the scheme are incorrect. The VDP year does count towards 5 year eligibility. Highly committed low earning dentists do get some payments ; from last April dentists with commitment of 90% or more became eligible irrespective of earnings levels.

The survey provides an interesting snapshot of the views of ordinary dentists, and we think reinforces much of the analysis and judgements which underlay the Options for Change recommendations and our planned reform of the GDS.

The survey does not suggest that there is widespread dissatisfaction with the overall earnings levels available from NHS work. The NHS is also particularly valued for the security, clinical variety, and personal satisfaction that it can offer.

Most dissatisfaction is centered around a remuneration system dependent upon item of services fees. In contrast, the security and stability offered by regular payments such as capitation and registration payments is valued. This reassures us that the core feature of the new dental contract, a decisive break with item of service payments to a system offering far greater security and stability of income, is directly addressing the key problem that is currently undermining dentists' morale and commitment. We note that offering additional payments such as commitment payments alongside the item of service system does not, on its own, seem to significantly influence dentists' commitment or perceptions.

We note that the survey does suggest considerable uncertainty about the nature and advantages of the reformed dental service. This we are addressing in our information programme.

BDA RESPONSE TO THE BMRB REPORT ON THE DENTISTS' COMMITMENT PAYMENTS SCHEME

1. The BDA welcomes the findings of the BMRB Report as it reinforces many of the views we have held for some time now. The BDA has addressed two of the main negative aspects of the current GDS system in its evidence to the DDRB for its 33rd Report; those are NHS fees not being sufficient to cover the real cost of dental treatments and the administrative burden associated with running an NHS practice. The BDA has asked for a fee scale uplift that adequately addresses dental expense inflation and for a Practice Allowance to be introduced. The BDA hopes that this new (and independent) evidence strengthens the arguments that we have already presented to the DDRB in relation to these two issues.
2. Whilst the BDA appreciates the value of this qualitative research we would urge the OME to also undertake a quantitative analysis as soon as possible and for the findings be considered in conjunction with this draft report. At this stage we are, however, concerned that the sample size used (30 GDPs which equates to less than 0.3% of the total number of GDPs that receive commitment payments) may not be indicative of the GDP population, as a whole. In addition, the research failed to solicit the views of dentists' who (for whatever reason) do not receive commitment payments. As such, any inferences about the population need to be treated with caution.
3. Further, we are concerned with the areas selected to sample. The selected areas represent large conurbations (including the three capital cities) in each of the three countries of England, Wales and Scotland and thus may introduce unknown biases to the findings. In particular there is a significant over representation of female GDPs in the London sample and a significant under representation in the Cardiff and Leeds samples. Once again this may bias the findings when drawing conclusions.
4. There is evidence that some practice owners are retaining part of the associate's commitment payments. This needs to be explored further and quantified as such behaviour can only act to create a negative perception of the Scheme. The BDA's guidance states clearly that commitment payments are to be made to the practitioner who undertakes the NHS work and that these are paid in full.
5. The findings indicate that receiving commitment payments is viewed favourably, but there was a perception that it did not actually impact upon behaviour, in particular their decision to either stay or move away from the GDS. It is our contention that these findings imply that the CPS does have a significant positive impact on the morale of GDPs; something within the DDRB remit. The finding that the drift from the GDS might have been heightened if it had not been for this Scheme corresponds with the conclusion from the evidence prepared by the BDA in its evidence to the DDRB for its 32nd Report on the effectiveness of the CPS. Our analysis concluded that commitment to the NHS for GDPs who received commitment payments stayed stable from one year to the next compared with a significant reduction for those who did not receive payments.

6. The BDA would like to draw particular attention to the finding that the decision whether or not to work in private dentistry was generally made before the five-year eligibility point is reached. This finding was also identified in the OME commissioned report GDPs Workloads Survey 2000. As the current CPS does not make payments until a dentist has spent at least 5 years (continuous) service in the NHS then any conclusions linking commitment payments and the decision to either stay or move away from the GDS are seriously flawed, as both this report and the previous report (2000) concluded that this decision is made before individuals are even eligible for commitment payments. We would urge the DDRB to place considerable weight on this finding when considering this report. As such there may be substantial retentive impact for the GDS should the CPS reduce (or eliminate altogether) the continuous years of service eligibility criterion.
7. The findings of this report indicate that there was a strong feeling that the time spent in the GDS before a dentist becomes eligible for commitment payments needs to be reduced. It was also mentioned that the CPS should include time spent in salaried NHS posts and needs to consider those who take a career break before the five year eligibility criteria is met, e.g. women having children. With reference to these issues we would like to draw attention to the fact that the BDA has previously put evidence to the DDRB supporting commitment payments for salaried practitioners and has approached the DoH with alternatives for measuring NHS commitment, so as to not discriminate against part-time GDPs.
8. Top up payments are viewed favourably, and modifications to this characteristic of the Scheme may improve the impact on retention and morale, e.g. by paying an additional percentage incrementally at say 10, 15 and 20 years of service.
9. Whilst the BDA supports many of the findings in this report we have considerable concerns about the sample used and whether or not this is representative of the GDP population as a whole. As such the BDA would urge the DDRB to consider the findings cautiously, and in conjunction with further planned quantitative research, before any policy decisions with regards the CPS is made. The BDA fully supports the conclusion made in the report that *"... it would be problematic to stop the commitment payments scheme (unless it was replaced with an alternative) ... as dentists would undoubtedly view this unfavourably"*.

APPENDIX I

PREVIOUS REPORTS BY THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

1971	Cmnd. 4825, December 1971
1972	Cmnd. 5010, June 1972
Third Report (1973)	Cmnd. 5353, July 1973
Supplement to Third Report (1973)	Cmnd. 5377, July 1973
Second Supplement to Third Report (1973)	Cmnd. 5517, December 1973
Fourth Report (1974)	Cmnd. 5644, June 1974
Supplement to Fourth Report (1974)	Cmnd. 5849, December 1974
Fifth Report (1975)	Cmnd. 6032, April 1975
Supplement to Fifth Report (1975)	Cmnd. 6243, September 1975
Second Supplement to Fifth Report (1975)	Cmnd. 6306, January 1976
Third Supplement to Fifth Report (1975)	Cmnd. 6406, February 1976
Sixth Report (1976)	Cmnd. 6473, May 1976
Seventh Report (1977)	Cmnd. 6800, May 1977
Eighth Report (1978)	Cmnd. 7176, May 1978
Ninth Report (1979)	Cmnd. 7574, June 1979
Supplement to Ninth Report (1979)	Cmnd. 7723, October 1979
Second Supplement to Ninth Report (1979)	Cmnd. 7790, December 1979
Tenth Report (1980)	Cmnd. 7903, May 1980
Eleventh Report (1981)	Cmnd. 8239, May 1981
Twelfth Report (1982)	Cmnd. 8550, May 1982
Thirteenth Report (1983)	Cmnd. 8878, May 1983
Fourteenth Report (1984)	Cmnd. 9256, June 1984
Fifteenth Report (1985)	Cmnd. 9527, June 1985
Sixteenth Report (1986)	Cmnd. 9788, May 1986
Seventeenth Report (1987)	Cm 127, April 1987
Supplement to Seventeenth Report (1987)	Cm 309, February 1988
Eighteenth Report (1988)	Cm 358, April 1988
Nineteenth Report (1989)	Cm 580, February 1989
Twentieth Report (1990)	Cm 937, February 1990
Twenty-First Report (1991)	Cm 1412, January 1991
Supplement to Twenty-First Report (1991)	Cm 1632, September 1991
Second Supplement to Twenty-First Report (1991)	Cm 1759, December 1991
Twenty-Second Report (1992)	Cm 1813, February 1992
Twenty-Third Report (1994)	Cm 2460, February 1994
Twenty-Fourth Report (1995)	Cm 2760, February 1995
Supplement to Twenty-Fourth Report (1995)	Cm 2831, April 1995
Twenty-Fifth Report (1996)	Cm 3090, February 1996
Twenty-Sixth Report (1997)	Cm 3535, February 1997
Twenty-Seventh Report (1998)	Cm 3835, January 1998
Twenty-Eighth Report (1999)	Cm 4243, February 1999
Twenty-Ninth Report (2000)	Cm 4562, January 2000
Thirtieth Report (2001)	Cm 4998, December 2000
Supplement to Thirtieth Report (2001)	Cm 4999, February 2001
Thirty-First Report (2002)	Cm 5340, December 2001
Supplement to Thirty-First Report (2002)	Cm 5341, December 2001
Thirty-Second Report (2003)	Cm 5721, May 2003
Supplement to the Thirty-Second Report (2003)	Cm 5722, June 2003



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